DISCHARGE PLANNING
ADVISOR

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IN THIS ISSUE

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New research sheds light on improving discharge process for coronary patients

New therapies not always quickly adopted

Several new studies highlight the need for more thorough discharge planning in the care of coronary and congestive heart failure patients. Such patients often are elderly and susceptible to adverse events and drug-drug interactions from standard medication treatment.[1]

Also, there often is too long of a lag time from when new evidence leads to guidelines outlining a more optimal treatment to when the treatment is implemented by clinicians.[2]

This trend, in particular, is noted in the context of aldosterone antagonist use, in which less than one-third of eligible patients hospitalized for heart failure received aldosterone antagonist therapy as recommended in guidelines.[3]

The aldosterone antagonist-use study resulted from a review of the American Heart Association's heart failure database, says **Nancy M. Albert**, PhD, CCNS, CCRN, NE-BC, FAHA, FCCM, director of nursing research and innovation in the Nursing Institute, and a clinical nurse specialist at the Kaufman Center for Heart Failure in Cleveland.

Investigators identified 12,565 patients eligible for aldosterone antagonist therapy out of a database of more than 43,000 heart failure patients. All of the eligible patients had been treated at hospitals that participated with the Get with the Guidelines Heart Failure Program by the American Heart Association, a quality improvement initiative to improve usage of recommended evidence-based therapies.[3]

Only 34% of eligible patients, at the end of 2007, had been given aldosterone antagonist therapy at discharge, Albert says. (**See story on why recommended therapy was under-prescribed, p. 4.)**

Study findings reflect that physicians and discharge planners need to stay current with guidelines for managing heart failure, and they should develop systems or processes to enhance evidence-based practices, Albert says.

"They need to make sure patients are receiving optimal medical therapies that ultimately will improve survival and decrease hospitalization," she says.

Another study, published last fall in the *American Journal of Geriatric Pharmacotherapy*, showed that hospital clinicians generally were not offer-

ing medications that might be beneficial for elderly heart failure patients.[1]

For example, the use of ACE inhibitors in heart failure patients can be seen as an indicator of how well hospitals are taking care of these patients, says **Judy W. M. Cheng**, PharmD, MPH, FCCP, BCPS, RPh, professor of pharmacy practice at the Massachusetts College of Pharmacy and Health Sciences in Boston.

"And the percentage of use of ACE inhibitors is lower in elderly patients," Cheng says. "We don't know if these patients can't tolerate them, or if people are not as aggressive in treating their disease."

The problem with the drugs is they often cause patients' blood pressure to drop, or they might worsen kidney function, Cheng says.

"Because those patients are older, they're also more susceptible to experiencing orthostatic hypotension. When they change from lying down to sitting up, they get very dizzy, which is very common in older patients," she explains. "If patients are taking ACE inhibitors or beta blockers, which also impact blood pressure, then this will exacerbate this change in dropping blood pressure."

The aldosterone antagonist study's findings complement Cheng's research.

"It sometimes is difficult to add aldosterone antagonist, because people worry it will make patients' potassium levels dangerously higher," Cheng says.

"That makes physicians more reluctant to prescribe them," she adds. "So, a lot of times, they'll say, 'Let's discharge these patients and let the outpatient doctor take care of it.'"

Further research is looking at improving adherence to treatment guidelines for patients with cardiovascular disease.

The ongoing investigation suggests that hospitals can use electronic health records to rapidly identify patients who would benefit from medication adjustments, says **Allen Kachalia**, MD, JD, a medical director for quality and safety at Brigham & Women's Hospital in Boston.

In hospitals like Brigham & Women's Hospital, such electronic information could be communicated to physicians by e-mail, resulting in more rapid adherence to guidelines, he says.

"We're in the process of studying how effective this process is," Kachalia says. "This program was designed at Brigham to help Brigham primary care patients."

Investigators chose to communicate by having staff nurses e-mail physicians, because this method of communication doesn't disrupt doctors' workflow, he notes.

"In general, they all responded to us," Kachalia adds.

This particular study looks at how hospitals can improve the discharge process and reduce readmissions among patients with cardiovascu-

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lar-related diseases, including diabetes, coronary artery disease, heart failure, stroke, and chronic kidney disease.[2]

"The discharge process represents an opportunity to identify people at high risk for readmission, and then we can plug them into a program that will help prevent readmission," Kachalia says.

The process employed by Brigham & Women's Hospital is relatively inexpensive, since it was done with 0.4 nursing FTEs and a little bit of Kachalia's time as medical director, he notes.

"I took the lead and looked at national guidelines, coming up with what the indications were," he explains. "Then, the team verified them, and for each disease, we went to a resident specialist and built in a list of what we'd screen people for and what medications to prescribe."

The specialists made sure the information was correct.

By engaging specialists in the process, the staff buy-in was easier to obtain, Kachalia says.

"We went to primary care physicians and would say, 'We looked at the guidelines, and our specialists say this is how we should operate,'" he says.

The primary care physicians agreed but made a suggestion: "They wanted e-mails sent much closer to when patients would come back to see them, rather than three months in advance," Kachalia says.

Hospital clinicians defer to primary care physicians on timing and ordering medications, but they follow cases continuously to make sure medications recommended in guidelines are prescribed, he says.

"We follow patients for three weeks after discharge and then follow indefinitely," he explains. "The idea is to have continuous monitoring, and we can do this with electronic charts."

The electronic health database can be programmed to provide reminders about checking up on patients or calling primary care physicians if there's a medication issue, Kachalia says.

The results of this process soon will be available.

"We're going to see what data show, and we hope we'll see a benefit that could result in a best practice," Kachalia says.

Clinicians involved in discharge planning should consider giving heart failure patients an ACE inhibitor to start, and The Joint Commission of Oakbrook Terrace, IL, wants documentation for reasons behind any decision not to prescribe ACE inhibitors when patients meet criteria for them, Cheng says.

In Cheng's research, this problem appears to be primarily in the care of elderly heart patients.

"I'm not sure why we're not meeting a high level of compliance," she says. "It's troubling."

If a hospital physician declines to prescribe an ACE inhibitor at discharge because he or she wants to leave the decision to the patient's community physician, then this can be a big mistake, she notes.

Hospital doctors might think the outpatient doctors will take care of these details, Cheng says.

But when patients see their community physicians, these doctors often think that if the hospital doctors didn't prescribe certain drugs, then maybe the patient doesn't need them, she adds.

The key is to improve discharge communication between hospital clinicians and patients, as well as between the hospital and community clinicians, Cheng says.

"I know it's easy to say and hard to do," she says. "I think if a hospital physician makes a conscious decision that the outpatient doctor might be able to take care of it once the patient is more stabilized, then the hospital doctor should communicate this very clearly to the outpatient doctor."

Another strategy would be for the hospital doctor to prescribe a very low dose of the new medication, just so the medication would be on the patient's profile, Cheng adds.

"This is so the outpatient doctor would be more likely to titrate the dose up rather than to not even think about starting the drug," she explains.

One strategy in improving discharge planning with cardiovascular patients is to list the recommended therapies on a discharge assessment sheet and physician order set, Albert suggests.

"When the patient is discharged, then we can pick up on any therapies that were not appropriate or were appropriate but not fully utilized," Albert adds.

Also, if a therapy is recommended but not prescribed at discharge, then the discharge paperwork will highlight this discrepancy.

The goal at discharge is to make sure patients receive the optimal medical therapies, so that they have the best chance of improved quality of life, that they have improved survival, and do not need early rehospitalization, Albert says.

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Lack of adherence in heart failure therapy

Educate and monitor to improve results

When research suggests changes in standard medical practice, the public health community expects physicians and hospitals to adopt the new way and help improve patient outcomes.

But occasionally, as one study recently found, the medical community is very slow in adopting new treatment recommendations.

A good example of this is what has happened with hospitalized heart failure patients who are eligible for aldosterone antagonist therapy, according to a large database study, published in the *Journal of the American Medical Association* late last year.[1]

The study found more than 12,000 patients who were eligible for this therapy, which research has shown would have improved their health outcomes. But only about one-third of these patients had received the therapy, which was recommended in several national guidelines.[1]

The research was limited by what physicians had documented with regard to contraindications, says **Nancy M. Albert**, PhD, CCNS, CCRN, NE-BC, FAHA, FCCM, director of nursing research and innovation in the Nursing Institute, and a clinical nurse specialist at the Kaufman Center for Heart Failure in Cleveland.

"Maybe a patient had a contraindication, and the doctor knew it but didn't document it," Albert says. "If they didn't document a contraindication with therapy, we would assume the patient was eligible to receive therapy."

The analysis began in January 2005, and continued through December 2007, and there was a steady trend from baseline of improvement in the guideline-recommended use of aldosterone antagonist therapy from 28%, when the study began, to 34% when it ended, Albert says.

"The American Heart Association and American Cardiology Association gave their stamp of approval for using aldosterone in patients in 2005," Albert says.

So investigators expected to see increased use of aldosterone antagonist therapy after the guidelines were updated. But they were surprised it was only a small increase, she adds.

This lackluster response to changing to using aldosterone antagonist therapy might have been due partly to a small discrepancy in how the guidelines were worded in 2005, Albert says.

"The guidelines should have said the treatment was recommended, but instead said it was reasonable to use an aldosterone antagonist, and that doesn't have as strong a connotation," she explains.

Although a correction was published in 2006, it's possible that many physicians didn't see the correction, she adds.

Also, none of the national performance measures for hospitalized heart failure patients include aldosterone antagonist therapy as a core measure yet, Albert notes.

"It could be that hospitals were so focused on doing what they had to do based on The Joint

Commission's performance measures and other expectations that they didn't take the next step of doing what was right based on the guidelines," she says.

Another factor is that one aldosterone antagonist is a generic drug that has been available as a potassium-sparing diuretic for years, Albert says.

"When we use it as an aldosterone antagonist, it's at a different dosage and it's for a different reason," she says. "Because the drug has been available for many years, there has been no drug company marketing of the drug, so maybe lack of use is that it's out of sight and out of mind."

Some physicians might have been reluctant to prescribe aldosterone antagonist therapy because of the drug's side effect profile, Albert says.

If the patient is already on some other therapies that are used to treat heart failure (such as an ACE inhibitor or angiotensin receptor blocker), they might have a higher risk of increased serum potassium and creatinine levels, she explains.

"So, maybe some health care providers were focusing on providing ACE-1 or ARB therapies, and maybe they had intended to start aldosterone antagonist therapy after the patient went home," Albert says.

The database did not yield information about therapies initiated after discharge, she adds.

The point is that while there are numerous reasons why providers might not have followed the national guidelines, the fact is that for most patients deemed eligible for the treatment, the guidelines should have been followed, leading to improved patient outcomes over time, Albert says.

Since this is an area that has fallen through the cracks, it would be a worthwhile quality improvement project for discharge planners to raise awareness about the treatment and include information about aldosterone antagonists in discharge planning paperwork for patients who meet criteria for use, he notes.

"Hospitals could monitor the use of the therapy in patients with systolic heart failure," Albert says. "If you have a registry or database, then you could keep track of your own data, and over time you should see the frequency of aldosterone antagonist use increase in patients who meet recommended criteria for receiving it."

SOURCE

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Improve DP with interdisciplinary focus

Hospital's LOS declined significantly

A regional hospital in a Southern rural state found that its hospital discharge process improved when the institution focused on refining its goals and improving collaboration between disciplines.

"About four years ago, our administration made the decision to refine our goals and bring our goals closer to what people at the bedside provided in care," says **Angie Roberson**, RN, BSN, CPUM, director of case management at Spartanburg Regional Medical Center in Spartanburg, SC.

For instance, the administration changed and enhanced the length of stay (LOS) goals, she says.

"All of a sudden, it gave me the opportunity to step through some new doors," Roberson says.

"What was interesting is right off the bat, I had a nurse manager say, 'I guess you feel a lot of pressure now that LOS is a goal,'" she recalls. "I said, 'I do feel pressure, but you should feel it too because length of stay is a shared goal.'"

The nurse manager's initial response was an eye-opener for Roberson.

"I realized I had a lot of work to do," she says.

As a result of the project to improve discharge planning, the hospital's length of stay has steadily declined from a baseline of 5.9 days for a severity-adjusted Medicare population to 4.68 days, Roberson says.

"We're a trauma center and major referral for

small hospitals in our region," she adds. "So we get all trauma cases and cardiac surgeries, and we don't just take short LOS kinds of things."

The LOS decrease is a testament to the collaborative spirit and work across the hospital system, Roberson says.

"It doesn't just happen in nursing and case management," she adds. "We also work with radiology and other departments, and as soon as we identify a glitch in the system, we go to that department and say, 'We saw this happen,' and then they'll work collaboratively with us."

There already had been some collaboration in discharge planning since different disciplines were seeing patients, and case managers were talking to everyone involved and putting together a good discharge plan, Roberson says.

"But we really didn't have the buy-in and true interdisciplinary collaboration that was needed at all levels," she explains. "It became evident that it was something I had to work on, so it could become a culture change."

Managers cannot force people to collaborate. It has to be something that evolves as employees' work culture evolves, she adds.

"We made this part of our strategic goals, and we have a monthly report card that goes out to staff, and we use that as our springboard," Roberson says.

Roberson began by speaking with the vice president of nursing and the vice president of quality, case management, and perioperative services.

"I said, 'This is what I see; here are my ideas, and this is what I'd like to do to create a nursing and case management collaboration," she says.

"Case managers were part of the nursing unit, although they don't report to the nurse manager and instead report to case management," Roberson explains. "But their work space is on the nursing unit, so I needed their buy-in and support."

Roberson suggested a theme they called "the power of nursing and case management collaborating."

"First and foremost, we were having interdisciplinary rounds on the unit twice a week," Roberson says. "We were having conversations we were bringing nursing into, and we were suggesting that every morning the charge nurse and case manager have a 15-minute huddle, reviewing their plans for the day."

Also, once or twice a week, they would discuss difficult cases on the unit, bringing in physical therapy, occupational therapy, nutrition, and sometimes the physician to help identify roadblocks and how everyone could work together to best resolve the issues, she adds. **(See brief story on holding huddles, p. 7.)**

"We were changing the case management model," Roberson notes. "We were moving away from a model where case management on the unit did everything, including governmental utilization review and discharge planning."

The utilization review portion of the workload was suffering, because it was left to the least experienced staff, she says.

"That wasn't acceptable," Roberson says. "I knew more and more scrutiny would be placed on medical necessity."

One main cause of the problem was that the discharge process had become so complex, and the utilization review process had become complex, she adds.

The organization tackled the problem by separating the roles case managers typically had and dividing these into the duties performed by a nurse case manager, who would do the utilization review and initial assessment, and the discharge planning case manager, who is a social worker or nurse, Roberson says.

"Staff members wanted to do all of the pieces, but the problem was the priorities were conflicting, and so it was a no-win situation when you had the combined role," Roberson says. "It was a problem of conflicting roles, and the size of our facility wasn't conducive to that model anymore."

Although the seven-year-old case management model had worked well when initiated, health care is constantly evolving, and models should change too, she adds.

"What I told our staff was that we'd hit the backspace button one time and split the role apart," Roberson says. "I wanted to use this opportunity to kick off a collaboration between nursing and case management."

The key was to help nurses understand the changes and how it would impact them.

"I also knew that if we were going to be successful with our length of stay goals, I needed nursing and case management to work like a well-oiled machine," Roberson says. "I needed them to understand that we're a team, and we need each other to be successful for our goal."

Both the vice president of nursing and the vice president of case management agreed with this goal and helped promote the change.

"So, we had a kick-off and invited every case manager and charge nurse and clinical nurse

educators who were responsible for education in our division to attend a lunch in a large auditorium," Roberson says. "We played the song 'Life is a Highway' because this was a journey, and we wanted them to see we were on a road and heading somewhere exciting."

Every nursing unit was represented, and the entire case management team attended, she adds.

The two vice presidents, along with Roberson, spoke at a two-hour session, first having attendees divide into small groups to engage in an ice-breaker exercise.

"Then I explained what was happening in case management and why it was happening," she says. "We explained some of the things we wanted to happen — like the daily huddles — where we wanted to include our communication to the patient in preparation for discharge."

For example, case managers and nurses will say this to a congestive heart failure patient: "We expect you'll probably be here three to four days, and our goal is to get you back on track as soon as possible," she explains.

Roberson also explained to case manager nurses that these changes were part of the hospital's strategic goals, including the goal to provide quality care for patients.

The kick-off session had its intended effect: The next day, the staff began to hold the huddles and communicate more effectively.

About nine months into the project, Roberson attended a meeting attended mostly by nurses, and the discussion centered around the discharge process.

"One nursing unit was still struggling and hesitant to accept things happening on the other units," she recalls.

But Roberson and other leaders didn't have to explain the project to the struggling unit, because the other nurse managers who had made the change successfully spoke up and quizzed them, asking, "Are you having huddles every morning? These are the ways we have become successful on our unit…"

The key is to embrace collaboration, Roberson suggests. **(See story with additional tips on improving collaboration, p. 9.)**

"Through this process, we've also been able to improve collaboration and relationships with dietary, dietitians, therapists, and all occupational

Want to start the "huddle?" Here's how one hospital does it

Key is to make it quick

When hospitals start a discharge planning huddle, the key is to make it brief, an expert says.

"I tell the staff, 'You shouldn't spend more than 15 to 20 minutes on your morning huddle,'" says **Angie Roberson**, RN, BSN, CPUM, director of case management at Spartanburg Regional Medical Center in Spartanburg, SC.

Hospital charge nurses and case managers can review the morning unit census and briefly discuss any patient issues.

For instance, a nurse might say, 'Mr. Jones had a bad night last night and had to have IV pain medication four times, so if you were planning on discharging him today, that would not be a good idea,'" Roberson says.

Or the nurse might say a patient has had a setback and needs to be monitored.

"The huddle is a quick rundown of the census, not a detailed discussion or problem-solving time," Roberson says. "It's 'What are you planning today?' or 'I got transportation arranged for Mr. Jones at 10 to go to the nursing home — will that work for you?'"

Another huddle discussion might involve making certain the patient will receive the antibiotics or other medications he or she will need when discharged home, she adds.

"You put your heads together and huddle it out, running down the list of patients," Roberson says.

If there's a case that needs more detailed discussion or input from additional disciplines, then it can be brought up at the less frequent multidisciplinary rounds, Roberson suggests.

"Once or twice a week, there's a multidisciplinary round where they take a look at cases that are not moving along," she explains. "These are cases where everyone expected the patient to go home yesterday, but he's still here."

The discussion at multidisciplinary rounds centers around what the patient's barriers are to being discharged and what can be done to overcome these, she adds.

"It could be that we need to have a family conference, because they have a lot of questions and don't understand what the doctor is saying to them," Roberson says.

"These are longer and more detailed discussions about cases that are not moving along," she says. "You have to have that communication about these kinds of cases, and it's not the same thing as the huddle." ■

SOURCE

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therapy and speech/language pathology," she adds. "We've increased communication between all therapies." ■

Tips on long-term steps to improve discharge planning

Work with community partners too

When Spartanburg (SC) Regional Medical Center began a process to improve its discharge planning process, it began with improving collaboration from both within the hospital and within the larger medical community.

The hospital system has a long-term acute care hospital, and the goal was to improve collaboration with this facility, says **Angie Roberson**, RN, BSN, CPUM, director of case management.

Previously, hospital staff had the attitude that the long-term care facility wouldn't take some patients, and there were misunderstandings about why this occurred, Roberson notes.

"It was an 'us' against 'them' kind of thing," she says. "We've overcome that to the point where case managers now work off the same piece of music."

Case managers now accept the fact that sometimes the long-term care facility cannot take certain patients, because it's not appropriate, Roberson says.

Here are more examples of how the hospital has improved its discharge planning and collaborations:

• **Develop a good relationship with nursing home staff:** "We also have a nursing home collaboration, and we have the same spirit with our outside partners as we do with other hospital units," she adds. "We place a lot of patients in nursing homes, so we have to have a good relationship with nursing home staff."

The hope is that if hospital professionals working in discharge planning treat the nursing home staff well, then this will make an impression and lead to a better collaboration in finding beds for hospital patients, Roberson says.

"If you want them to work with you, they need to know you and feel like you're there for them — it's all about collaboration," she explains. "So, we try to employ that collaborative spirit."

So far, the collaboration between the hospital and nursing home has led to success in decreasing the LOS of patients transitioning to the nursing home, Roberson says.

"We've had some good success, and you have to attribute it to the relationship and collaboration," she adds.

• **Designate a liaison between hospital and nursing homes:** "We have one geriatric case manager who is a liaison between us and the nursing homes," Roberson notes. "This case manager doesn't carry a case load, but she works with unit-based discharge planners, coordinating between them and nursing homes."

For example, the liaison case manager stays up-to-date on data related to nursing home placement.

"Each day, the nursing homes send out a list in an e-mail, saying, 'I have this many female and male beds available,'" Roberson explains. "Based on that list, we know what's available when we work with our patients every day."

When the hospital has a complex patient to transition, the liaison case manager will call the nursing homes and describe the patient's situation to find the best place to transition the patient.

The key is the liaison knows the facilities firsthand.

"She knows which place works well with dementia populations and which do well with wound care," Roberson says. "She calls the facilities and says, 'We have this patient, and I wish you'd take a look at this patient, because I think you would be a perfect answer.'"

Her work helps both the hospital and nursing homes, because her advance information gives nursing homes a better picture of the patients they'll be seeing, she adds.

• **Improve communication with physicians and families:** Discharge planning nurses and case managers need to be sure they're communicating regularly with physicians, Roberson says.

They need to ask a physician when he or she

anticipates a particular patient will be ready for discharge, she adds.

"We have to keep physicians involved," Roberson says. "It's all about communication and having everybody on the same page."

This also means that discharge planners should keep patients and families abreast of their plans, including them in the discharge planning process, she says.

Part of improving communication is learning the ways to express transitions and discharges without raising concerns in patients and families.

For instance, discharge planners should frame the discharge planning process in terms of improving patients' quality of life.

They might say to a patient: "It's important to us that we get you better as soon as possible and get you back home to your regular routine as fast as possible," Roberson suggests. "So, at the very beginning, we talk about what they're going to need at discharge, so they won't think we're trying to kick them out before they're well."

• Keep a communication board in each patient room: "We want to have dry-erase boards in every patient room, so we can put on their anticipated discharge date," Roberson says. "It's a challenge, and we haven't quite gotten there yet."

When discharge planners use this method to keep the discharge goal in everyone's mind, then it'll be even more important to be careful about how this is discussed with patients, she notes.

"It'll be really important that the words we use are positive," she says.

For instance, discharge planners can say "If everything goes well and you stay on track, then at this date we'll have you ready for discharge; our goal is to take good care of you and get you back on your feet," Roberson says.

The idea behind the dry-erase boards is to keep the discharge date visible to family members, so they can make plans and juggle their schedules to be available on the day when their family member is returning home. ■

Sharing resources helps create cost-effective DP

Hospital also uses collaboration to improve outcomes

As hospitals nationwide seek ways to reduce their readmission rates and improve quality, they are having to make improvements with fewer resources.

So, one strategy is to seek collaborations from other departments and researchers in the hospital system, looking for ways the two groups can pool resources and reduce redundancy.

For instance, when the Medical University of South Carolina (MUSC) in Charleston, SC, became involved in Project BOOST, the physician champion for Project BOOST looked for other active initiatives at MUSC to find natural collaborative fits.

Project BOOST - Better Outcomes for Older adults through Safe Transitions — is sponsored by the Society of Hospital Medicine in Philadelphia, PA, through a grant from the John A. Hartford Foundation.

Through a collaboration, a hospital can improve funding for particular positions and more quickly spread best practices and helpful tools, says **Neal Axon**, MD, an assistant professor of internal medicine and site director for Project BOOST at MUSC.

"When we started with BOOST, we made sure we included other initiatives active at MUSC," Axon says.

A tertiary care university center with a wide variety of patients, including chronically ill and indigent patients, MUSC has a challenging patient population, Axon says.

The organization became involved in Project BOOST as a way to improve its readmission rate on the internal medicine unit, which is attended primarily by resident teams, he explains.

"We chose that unit because we have a readmission rate on that unit that represented an opportunity for improvement," Axon says. "So, we wanted to use Project BOOST as a first step of continuing quality improvement strategy as part of re-engineering the discharge process."

Axon and other BOOST leaders were aware of several other MUSC initiatives to improve the discharge process, and they thought there might be an opportunity to collaborate and take advantage of these.

"What we wanted to avoid is having three or five small camps of people in the medical center working on essentially the same problem," Axon says. "We wanted to bring everyone onto the same page."

For example, the institution already was involved in a project called Aging Q3, which involves teaching geriatric care to medical students and resident doctors, Axon says.

Aging Q3 is focused on improving the quality of education, care, and life for older patients, and it is the result of a $2 million grant, covering 2009-2012, from the Donald W. Reynolds Foundation.

The Aging Q3 grant funding partially pays the salary of the nurse/research associate position, while the hospital also contributes a portion of the salary on behalf of Project BOOST, Axon adds.

"So, having these two projects running in parallel has allowed for collaboration," Axon says.

"For example, some of the curricula we're going to be developing for Aging Q3 fit very nicely with Project BOOST," he says.

"And there's funding for a nurse/research associate through this separate grant," he adds. "It's far from done, but they're in the process of writing a job description and hiring a person who will help facilitate the execution of the grant with a portion of that person's salary being paid by our hospital in support of Project BOOST."

The focus on improving discharge planning also will be aided by the hospital's adoption of a computerized provider order entry (CPOE), which soon will be rolled out. It will include a revised discharge order set, Axon says. **(See story about revising electronic discharge order forms, p. 11.)**

Another collaboration involved the hospital's cardiology group, which had been considering participation with the Hospital to Home (H2H) national quality initiative, cosponsored by the American College of Cardiology and the Institute for Healthcare Improvement, Axon notes.

"H2H is very well done and has many features similar to BOOST, so they sought me out as somebody who was knowledgeable about BOOST," Axon says. "So, we're likely to be working with them to implement BOOST with a twist for heart failure patients."

If Axon had not publicized among MUSC's staff the hospital's focus on improving discharge planning and care transitions, then the cardiology physicians might have invested time and resources into a separate program that would have duplicated some of the ongoing efforts under Project BOOST, he says.

"I can promise you that I'll be tapping on them for assistance as we configure and recalibrate our quality efforts around congestive heart failure and myocardial infarction because they're the experts in that," Axon says. "And they do that better than other parts of our medical center that don't see as much heart failure." ■

CNE *questions*

1. Of eligible patients, what percentage were given aldosterone antagonist therapy at discharge?
   A. 85%
   B. 62%
   C. 52%
   D. 34%

2. Which of the following is a strategy that helps to improve discharge planning through collaboration with different disciplines, according to Neal Axon, MD, an assistant professor of internal medicine at the Medical University of South Carolina in Charleston, SC?
   A. Hold interdisciplinary rounds on the unit twice weekly.
   B. Hold daily, brief huddles to review plans for the day.
   C. Move away from case management model where CM does everything having to do with discharge planning.
   D. All of the above

3. Which of the following is a pointless feature on a discharge order form, creating unnecessary clutter according to Neal Axon, MD, an assistant professor of internal medicine at the Medical University of South Carolina in Charleston, SC?
   A. Disease-specific instructions
   B. A table listing every possible discharge disposition from home to community
   C. Two pages of patient education material
   D. All of the above

4. Research shows that the use of ace inhibitors among elderly patients is lower than indicated. Which is a possible reason why this occurs?
   A. The drugs often cause patients' blood pressure to drop, and physicians may be reluctant to take that risk.
   B. These drugs show less efficacy in elderly populations.
   C. Medicare reimbursement is inadequate for these medications.
   D. None of the above

Answers: 1. D; 2. D; 3. B; 4. A.

SOURCE

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Electronic formats mean it's time for change

Patient education was expanded

When the Medical University of South Carolina (MUSC) Charleston, SC, prepared to switch to computerized provider order entry (CPOE), one of the first steps for the staff focused on discharge planning was to revise the discharge order set.

"We had a somewhat dated discharge form, which wasn't user-friendly or particularly helpful for patients," says **Neal Axon**, MD, an assistant professor of internal medicine and site director for Project BOOST at MUSC.

"Like many forms, it suffered from a few generations of tweaks done by different people," Axon says.

"Some of its worst features were that it was unnecessarily cluttered and often completed incorrectly by residents and doctors," Axon explains. "For example, a table that occupied half the page listed every possible discharge disposition from home with no home health services, to home with physical therapy, to home with occupational therapy, and more."

The table included every possible variation, including transitions to long-term care and rehabilitation facilities, he adds.

"At one point in our institution's history, these had been important to track," Axon says. "But it really wasn't essential to discharge processes today, and my feeling and the feelings of others was that we could better use that space and redesign the form."

Another problem was that the form had too little space dedicated to patient education.

So, when the form was revised, the patient education piece was expanded to cover two pages.

"The patient education went from a photo-

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **May/June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

CNE objectives

To earn continuing education (CNE) credit for subscribing to *Discharge Planning Advisor*, CNE participants should be able to:

- Identify particular clinical issues affecting discharge planning.
- Apply discharge planning regulations to the process of discharge planning.
- Describe how the discharge planning process affects patients and all providers along the continuum of care.
- Cite practical solutions associated with the discharge planning process based on independent recommendations from clinicians working in the field or from specific regulatory bodies. ■

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copied, hand-written back half of a page to a two-page, tight document that is much more easy to follow," Axon says. "It's legible and is typed."

Patient education information is available on existing forms for patients with congestive heart failure, acute myocardial infarction, asthma, and other disorders, he says.

The new discharge form is longer, but it's easier to complete, he notes.

"I've had several of the resident doctors say that when we were piloting it, they swallowed hard and cursed to themselves," Axon says. "But after they completed it, they said, 'This form is great.'"

The form was pilot-tested and now is being tweaked. When it's improved and approved, the hospital will roll out a new discharge order set across the institution, Axon says.

The last step will be to make it available in electronic format and plug it directly into the discharge summary module that is part of the CPOE, he adds.

"Right now these are in printable, PDF format," Axon says. "In order to reduce redundancy, the information you complete on the first three pages is automatically filled into the last two pages, which is the patient education piece."

The idea is to have staff log onto the computer, click on the discharge summary module, and then complete several tabs, including a quality tab, he explains.

The discharge form will ask questions pertaining to core measures, such as the following: Does this patient have congestive heart failure?

"What we envision is a one-stop shop for improving our compliance with core measures, and it will be a part of the discharge summary module," Axon says. ■

Study: Hospital patients lack knowledge

Most could not recall drug names

A new study published in the *Journal of Hospital Medicine* highlights the problem of hospital patients being unaware of their own medications.[1]

Investigators found that 44% of patients thought they were receiving a medication that they had not been prescribed. And only 4% of patients were able to remember the names of all of their prescribed medications.[1]

This education deficit poses a safety risk for hospital patients since patients who know their medications might be able to prevent the wrong medication from being administered.

There were 50 study participants, ages 21 to 89, and all said they knew all of their outpatient medications. They spoke English and were from the community around the University of Colorado Hospital.[1]

Patients who lived in nursing homes or had a history of dementia did not meet the study's criteria.[1]

Reference

1. Cumbler E, Wald H, Kutner J. Lack of patient knowledge regarding hospital medications. *J Hosp Med.* 2009;10.1002/jhm.566. ■

Dear *DISCHARGE PLANNING ADVISOR* Subscriber:

This issue of your newsletter marks the start of a new continuing nursing education (CNE) semester and provides us with an opportunity to review the procedures.

DISCHARGE PLANNING ADVISOR, sponsored by AHC Media LLC, provides you with evidence-based information and best practices that help you make informed decisions concerning treatment options and physician office practices. Our intent is the same as yours — the best possible patient care.

The objectives of *DISCHARGE PLANNING ADVISOR* are to:

- **identify** particular clinical issues affecting discharge planning.
- **apply** discharge planning regulations to the process of discharge planning
- **describe** how the discharge planning process affects patients and all providers along the continuum of care.
- **cite** practical solutions associated with the discharge planning process based on independent recommendations from clinicicans working in the field or from specific regulatory bodies.

Each issue of your newsletter contains questions relating to the information provided in that issue. After reading the issue, answer the questions at the end of the issue to the best of your ability. You can then compare your answers against the correct answers provided in an answer key in the newsletter. If any of your answers were incorrect, please refer back to the source material to clarify any misunderstanding.

At the end of each semester, you will receive an evaluation form to complete and return in an envelope we will provide. Please make sure you sign the attestation verifying that you have completed the activity as designed. Once we have received your completed evaluation form, we will mail you a letter of credit. This activity is valid 36 months from the date of publication. The target audience for this activity is hospital-based discharge planning advisors.

If you have any questions about the process, please call us at (800) 688-2421 or outside the United States at (404) 262-5476. You also can fax us at (800) 284-3291 or outside the United States at (404) 262-5560. You also can e-mail us at: customerservice@ahcmedia.com.

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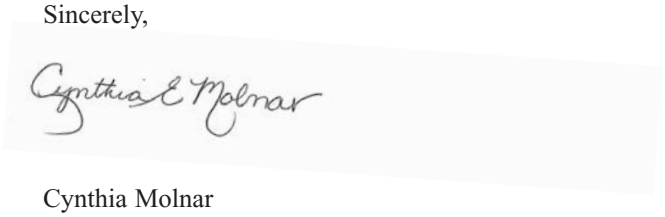

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