DISCHARGE PLANNING
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Health system makes effort to handle short discharge opportunities

Admissions from ED leave little time to plan

When patients are admitted through the emergency department (ED) and multiple clinicians are involved with competing priorities in their care, discharge planning can be challenging.

One solution is to improve communications between providers while targeting more effective patient communication at discharge.

"We identified communications with regard to discharge and education as being very important," says **Katie Starkey**, MS director of patient experience initiatives at Albert Einstein Healthcare Network in Philadelphia.

The goal was to improve patient education and make it routine to follow up with primary care physicians (PCPs) to give them more information about the patient's hospitalization, she adds.

"There are a number of competing priorities that make it more difficult to make sure patients have everything they need when they leave the hospital," says **Mary Beth Kingston**, RN, MSN, NEA-BC, vice president and chief nurse executive at Albert Einstein Healthcare Network.

"About 80% of our admissions come through the ED, so we are less able to have scheduled admissions than other organizations," Kingston explains. "Our length of stay averages about 4.7 days, so that's a pretty tight LOS."

Although discharge planning begins at admission, it's still difficult to ensure patients have the information and other things they need at discharge, she adds.

"We can't discuss the discharge prior to admission like you can with surgical patients," notes **Cindy McGlone**, MBA, vice president–healthcare services at Albert Einstein Healthcare Network.

"We're trying to increase our patient satisfaction with the discharge process," McGlone says.

The health care organization's survey identified two discharge-related questions to target, Starkey says.

"When we looked at our results compared with the national average, we were below where we wanted to be on these items," she explains. "So, we implemented changes with our discharge instructions, which has improved our performance."

For example, a question on the survey asked patients, "Did you receive written instructions about the symptom or problem when you went home?"

After changing the discharge form to improve instructions, the hospital has seen an improvement in this area, Starkey says.

Identifying communication at discharge as a possible quality improvement initiative was a first step to improving the entire discharge process.

The hospital's discharge planning team has found that the first 24 hours after admission are a crucial time for the discharge process.

"Within the first 24 hours, the patient is assessed with a care management assessment," says **Donna Antenucci**, RN, senior director of care management.

Nurses do the initial assessment, and a multidisciplinary team that includes nurses, physicians, a case manager, and a social worker does a daily round, looking at all of the patient's issues, she adds.

"We look at what the patient's previous status was and how we can get the patient back to baseline," Antenucci says.

The multidisciplinary team also includes physician residents, says **Steve Sivak**, MD, FACP, The Paul J. Johnson Chairman, department of medicine at the health system. Sivak also is a clinical professor of medicine at Jefferson Medical College and medical director of Einstein Community Health Associates, internal medicine and family practice in Philadelphia.

"We have a large patient population and a large residency, and we work hard to integrate this into the discharge process," Sivak says. "The team meets each morning to discuss patients, and we give residents a period of time after rounds to accomplish some of the tasks we identified at rounds."

The goal is to identify patients who have been given a discharge date, particularly as the patient is closer to discharge, he adds. It's also necessary to make patient education as effective and efficient as possible, since there is little time to repeat and reinforce teaching. One of the more effective ways to teach patients as part of discharge planning is to use the teach-back method.

"We use teach-back and have hands-on instruction to make sure nurses are using it as intended," says **Justine Sgrillo**, RN, clinical manager of nursing.

"We taught nurses how to speak simply," Sgrillo says. "It was a huge initiative, and we thought it'd be a simple process; but it was more difficult than we thought."

In the typical hospital's discharge process culture, nurses will meet with patients, read discharge instructions, and ask if patients understand, Sgrillo explains.

"Most patients will say, 'Yes,' because they don't want to show you what they don't understand, or maybe they don't understand what they don't understand," she says.

Plus, nurses are crunched for time and are trying to get through this part of discharge planning as quickly as they can. The key is to show nurses how important teach-back is, beginning with showing them patient survey results, Sgrillo suggests.

"We've done some health literacy work, teaching nurses to bring the educational level down to the patient's level of understanding," Sgrillo says.

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"We showed them statistics about how patients learn better through repetition, and we gave them statistics on how much is forgotten immediately after it's taught."

The hospital held an hour-long workshop on patient education and health literacy, says **Christine Charles**, MS, patient education coordinator.

"The video showed how patients felt about going to the doctor, and we had nurses role-play, practicing their interactions and good communications with patients," Charles says.

Spot checks during discharge planning also help.

"We do that weekly," Sgrillo says. "We do a lot of one-on-one teaching, and we look at copies of forms to see who is doing it well and who is not."

By making follow-up visits to the unit, discharge planning leaders give nurses an opportunity to ask questions and discuss issues that arise, Charles says.

"There's a point person on the unit who presents as a resource," Charles adds. "So, when I'm not available, other nurses can provide guidance for nurses."

Managers give nurses examples of well-written discharge forms. A typical discharge sheet might be a couple of pages long, with dense text, and a writing level that proves to be a stumbling block to patients who have low-level literacy, she notes.

One helpful tool is Project BOOST's PASS forms, which provide discharge instructions in a patient-friendly format, she adds. Albert Einstein Healthcare Network is involved with Project BOOST.

"Patient PASS: A Transition Record" is a one-page form that covers the essential information in boxed sections. For example, the form's main section reads, "If I have the following problems…. I should…." Under the first part, there are five numbered lines, and under "I should" there are matching numbered lines.

Another box, titled "My appointments" lists four places to write appointments, dates, and times.

A third box, also followed by numbers with space for writing, reads, "Tests and issues I need to talk with my doctor(s) about at my clinic visit." And there are boxes for "Important contact information," followed by a place for patient or caregiver and providers to sign and a separate section for "Other instructions."

Another important strategy is to help the patient with scheduling follow-up appointments, Sgrillo says.

"You need to go over this with patients, because they won't attend a follow-up appointment if you don't find days that will work for them," she says. "Whatever is called for, we'll make the appointment, because we think that's so important in preventing readmission."

The hospital has had some success with its new discharge instructions, according to recent survey results, Sgrillo says.

"Our first quarterly scores show that 81.7% agreed that the nurse explained things understandably, and this compares with a 55% national average," she says.

The problem with any initiative is that staff interest is high at first, but then it will slack off.

"It has its peaks and lows, and we need to work on sustainability," Sgrillo says. "Interest drops off after six months, so we need to reinvigorate." ■

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Homeless patients often arrive through ED

Physician suggests DP role in their care

National reports indicate that cities across the United States are seeing double-digit jumps in the number of homeless people. Likewise, hos-

pitals are reporting increasing numbers of indigent and uninsured people needing care in their emergency departments (EDs).

Cities from New York to Los Angeles have reported increases in homeless people and families of 12% to 40%, according to a report by the Center on Budget and Policy Priorities in Washington, DC.

This means that hospital discharge planners increasingly will need to find ways to provide a safe discharge to the community for patients who do not have homes to which to return.

"In my daily job, I'm encountering homeless patients routinely," says **Jennifer Best**, MD, an assistant professor of medicine at the University of Washington in Seattle and an associate program director of internal medicine residency program at the University of Washington. Best also is the deputy editor of the *Journal of General Internal Medicine*, and she's with the hospital medicine program at Harborview Medical Center in Seattle.

Discharging homeless patients is a frustrating process, and often these patients have to be sent back to the streets, because social safety net organizations are overburdened, and there are no alternatives, Best says. So, Best has developed a guide for how to handle these patients.

When Best attempted to find practical recommendations in the literature for how to improve hospital discharges of homeless and indigent patients, she came up short. But she decided to summarize the advice and models that are available in a paper published in the *Journal of Hospital Medicine*.[1]

Not all hospitals see as many homeless patients as does the Harborview Medical Center, Best notes.

"But they probably will see more and more," she says. "So, we've developed a quick memory aid for people who may not see homeless patients as much as we do."

Here are some ways hospital case managers, social workers, and others involved in the discharge process can help improve care transitions of homeless patients:

1. Assess their housing status.

"That sounds basic, but if you look at it, hospitals are not required by any agency to collect homelessness data," Best says. "At our hospital, we take care of a lot of these folks, and sometimes that information is cobbled together by self-report — something that's in the chart."

Patients might enter an address for a homeless shelter when they enter the hospital, she notes.

The key is for discharge planners to become aware of which patients are homeless or who have unstable housing, including those who are staying with friends.

"Those who are staying with friends might be just as vulnerable as those living under bridges, which are the people we classically think of as homeless," Best says. "So, this needs to be assessed up front, and someone has to ask these questions."

Be direct: Ask if the patient has a home. If the patient says, "Yes," then ask, "Tell me about that. Who do you live with?" Best says.

If the patient responds that he or she is staying with a friend or has been staying at a shelter, then Best documents the response.

"Some folks who live at shelters have long-term relationships with those shelters," Best says. "For some patients, those are longer-term placements, and they might be there for years and years."

2. Screen for common medical conditions.

The goal is to screen for medical conditions that are common among homeless patients with the goal of preventing disease, Best says.

"The mortality rate of people who are homeless is really high," she says. "Their life expectancy is around 45 years of age, and almost any kind of chronic medical condition, heart disease, lung disease, diabetes, high blood pressure, liver and kidney diseases are at a higher frequency in people who are homeless."

Homeless people also are at higher risk of infectious diseases, including tuberculosis, HIV, and hepatitis, she adds.

"So, you need to be detailed when you first see a homeless patient, even asking them to disrobe entirely," Best says.

"We find that people who've become accustomed to sleeping in shelters don't want to take off their coat or bag," she explains. "Building trust is an important part of it."

When the homeless patient is disrobed, clinicians need to look for evidence of abuse, trauma, and skin conditions, Best says.

Also, hospital clinicians should accelerate homeless patients' vaccination schedules, giving them two doses of hepatitis A and B vaccine before they leave the hospital, she suggests.

"If they're using drugs, then counsel them on needle exchange and screen them for TB," Best adds. "Also talk with them about their substance abuse."

Studies have shown that homeless people who

are hospitalized might be willing to quit smoking, and a period of hospitalization could provide a good opportunity for support and counseling about this, she says.

3. Address primary care issues.

Hospital clinicians often focus on fixing acute problems, so thinking about primary care issues is outside their comfort zone.

However, for homeless patients, hospital physicians are their only primary care providers.

"What's interesting is the homeless patients I care for I see again and again and again," Best says. "I do have continuity of care."

So, hospital clinicians should consider checking homeless patients' cholesterol, and they should ask questions about primary care issues, she suggests.

"There should be an expanded role for hospitalists in providing some kind of primary care to people who do not have a primary care physician," Best says. "Make sure they're vaccinated for pneumonia and think about their blood pressure and things that are chronic."

Part of discharge planning could include facilitating screenings and consultations for primary care issues like colonoscopy in an inpatient setting, she adds.

Also, homeless patients with diabetes and diabetes complications need to be handled differently than typical hospitalized patients.

"We see people with skin and soft-tissue infection," Best says. "They have developed diabetic foot ulcer, and it's gone into the bone, because it's been left untreated."

These patients might need long-term antibiotics, and if they were the typical patient they'd be sent home with a nurse. But they don't have a home, and they can't be sent home with an IV line, Best says.

"So we send them to nursing homes," she says. "But if someone has substance abuse issues, nursing homes don't want to take them, and they'll end up in our hospital for weeks and weeks."

While there, clinicians can do a colonoscopy and start to work on their substance abuse issues while they're there, Best says.

4. Provide follow-up care.

The typical discharge follow-up of sending information via fax or phone calls to community providers does not work with homeless patients, since they don't have consistent PCPs, Best says.

"Sometimes you can ask a patient to carry a copy of their discharge summary with their stuff, and they'll go from hospital to hospital," she says. "If they have a discharge summary to show that doctor, then it might help facilitate their care."

If the health care system has after-care or community clinics, then providers can refer homeless patients to these facilities at discharge, she suggests.

"People who don't have a primary care provider might need a quick stopover to check their lab work, follow up on culture results, or to obtain other information that wasn't available at discharge," Best says. "So, we have a clinic where people can come for no more than a couple of visits, but it helps serve as a bridge."

For health systems that do not have access to an after-care clinic, providing follow-up care is more challenging.

"People can come back to urgent care or the emergency room, but it's not ideal," Best says.

Discharge planners need to think about more than the usual type of contingencies and take care of these before the patient leaves the hospital.

Hospital providers need to determine how best to give homeless patients screening tests where the results are not going to be available before they're discharged, Best says.

For example, if the patient is given a standard HIV test, then the discharge process should include a provision that the patient be given the rapid HIV test, where the results can be reported before discharge, or that discharge planners make arrangements for the patient to return to the hospital to obtain the test results, Best says.

Discharge planners also need to ask homeless patients how they might reach them after they leave the hospital, Best says.

"Many homeless patients do have cell phones," she notes. "So, you ask how you can reach them, or if you can call their mental health counselor if anything comes up."

5. Initiate an end-of-life discussion.

"This has to do with the idea that when people come very ill and homeless and have fractured relationships in their lives, then they don't have obvious decision-makers who will decide whether they are put on a ventilator," Best explains. "So, you need to have an honest discussion and thoughts about what you want done if they're critically ill."

Help the patient identify any emergency contacts, including friends, write a do-not-resuscitate (DNR) order if they choose, and identify advance directives, she adds.

"This allows them to have control over their lives," she says.

6. Keep discharge instructions simple.

"Keep them as simple and realistic as possible," Best advises. "Health illiteracy is a real problem for a lot of people, but it really affects homeless patients."

In her research, Best found that half of study participants felt it wasn't possible to follow medical advice at discharge.

"It was quite remarkable," she says. "We overestimate patients' ability to understand what we ask them to do." ■

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Survey: Too little thought given to senior care

This makes discharge planning harder

When discharge planners identify potential options for hospitalized, frail seniors who are stable but no longer can fully care for themselves at home, they face a huge obstacle in the emotions and family conflicts that come into play at discharge.

Families might not have considered that their mother's fall and resulting broken hip would mean that she cannot return to her formerly independent lifestyle. Or they might have thought that Medicare home health services would be provided, only to learn that the patient does not qualify for these.

The problem is that Americans give too little individual thought and planning for senior care, a new survey finds.

"About 73% of adult children have not done any planning for senior care," says **Paul Hogan**, co-founder and chief executive officer of Home Instead Senior Care of Omaha, NE. The senior care company, which has more than 550 offices in the United States and now is in 15 countries, sponsored a survey on how well families are planning for senior care.

Hogan also is a co-author of *Stages of Senior Care: Your Step-by-Step Guide to Making the Best Decisions*, a book published in late 2009 by McGraw Hill.

"Over 70% of seniors and adult children still think Medicare or Medicaid or their parent's pension will be enough to cover the cost of senior care," Hogan says. "We know that Social Security and Medicare will not cover it, and pension and savings are pretty bleak, too."

About 41% of seniors live on less than $12,000 a year in income, he adds.

"So, there are some dangerous misconceptions out there about who is going to be paying for their senior care and how much it costs," Hogan says.

The lack of funds for private-paid home and health services compounds the discharge problem, limiting options.

Discharge planners could improve the transition to home or another provider if they focused on starting the discharge process earlier, got the family involved sooner, and helped patients and families discover all of their options, Hogan suggests.

"One thing that's evolved over the past 10 to 15 years is that the number of options for senior care have grown, but the vast majority of seniors and families don't know what these are," Hogan says.

The Home Instead Senior Care survey also found that 71% of adult children could name only two non-family care options, and 66% of seniors also could name only two options. And the two options they most often cited were skilled nursing homes and assisted-living centers. *(See story on senior care survey results, p. 19.)*

Some of the options that are overlooked include a family's personal resources, including neighbors, friends, a church outreach ministry, and Meals on Wheels. These are free resources that can provide visits to a senior, transportation, and assistance with meals.

There also are senior centers, adult day care centers, retirement communities, hospice care, and centers that specialize in care of dementia and Alzheimer's disease patients, Hogan says.

"One of the things that struck me about our survey is that when asked to name their options, people defaulted to saying, 'nursing home,' overlooking a lot of resources at their disposal," he adds. "This results in a lot of fear and anxiety."

For instance, perhaps a senior has watched over a neighbor's dog for years. So, now when the senior needs help getting to the grocery store, wouldn't the neighbor be willing to help? he says.

These are the kinds of things that discharge planners could ask patients about and have families look into, particularly when they are anxious about what will happen to their parent when they return home from the hospital with no in-home medical care.

Hospital discharge planners who wait until their elderly patients are about to leave the hospital to discuss their transition options probably will see readmission rates rise as the patient returns home only to have further problems requiring a rehospitalization.

"Hospitals need to do more to identify the next provider for patients before they're discharged," Hogan says.

One option is for discharge planners to use an Internet search to find low-cost options and services available in the patient's home town, he suggests.

Social workers can tap into this resource, as well, when they have patients who have limited social support and little funding for in-home assistance.

Plan in advance

Discharge planners should encourage families to think about what provider they'll want to use before the patient leaves the hospital, Hogan says.

"Talk about it in advance, so it doesn't come down to the last hour, or when the daughter is driving mom home and hasn't given this much thought," he says.

Hogan's company provides in-home assistance for seniors worldwide, including companionship, light housekeeping, medication reminders, errand assistance, and personal care. There is no medical care, and it's all paid through private funding.

"Hospital discharge planners call us quite often, and it's usually at 11 a.m., and they say, 'Mrs. Johnson is going to get out of the hospital today, and we need help,'" Hogan says.

Based on Hogan's experience, the four chief things patients need when they're discharged from the hospital are as follows:

- good nutrition and assistance with meals;
- assistance with taking medications on time;
- a good night's sleep;
- and reminders and transportation to make their medical appointments.

"If those four things do not exist, the likelihood of their being readmitted in 30 to 60 days is very high," Hogan says. ■

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Survey sheds light on lack of senior planning

Senior care isn't made a priority

A new survey, conducted by a worldwide company that provides private, in-home care for older adults, suggests that older Americans and their adult children do a poor job of planning for their future needs as health begins to fail.

The survey, conducted by Home Instead Senior Care of Omaha, NE, had these findings:

- 73% of U.S. adult children and 65% of Canadian adult children say they have not planned or thought about their parents' care needs as they age.
- 50% of U.S. seniors and 58% of Canadian seniors likewise have not thought about their own care needs as their health begins to fail.
- 66% of seniors can name no more than two non-family care options.
- 67% of adult children have not used any potential information resources on senior care.
- 54% of seniors have not used information resources on senior care.
- Nearly 80% of seniors seem unaware of the need for long-term-care insurance.
- Seniors and adult children underestimate the cost of skilled nursing homes.
- About 25% of adult children are aware of adult day care centers, while 35% of seniors know these exist. ■

Ways a hospital can improve DP process

Communication gap should be tackled

While hospitalists can provide consistency in the care of hospitalized patients, there can be drawbacks when it comes to transitions in care.

At least one hospital has tackled this issue as part of a quality improvement project, initiated partly through Project BOOST.

"We recognize that from the hospitalist perspective, we have taken over more and more of inpatient care of patients," says **Christina McQuiston,** MBCHB, clinical director of senior services and a hospitalist at Asheville Hospitalist Group and medical director, senior services and Project BOOST team co-leader at Mission Hospital in Asheville, NC.

"There's a communication/information gap that did not exist in the past, when primary care physicians provided care continuity from inpatient to outpatient," McQuiston says. "In the past, the PCP took care of patients in the hospital, knew what had happened to them, and continued to see them when they left the hospital."

This is no longer the case.

"Our hospitalist group has done a very good job of coordinating with the hospital and getting paperwork to physicians in a prompt manner when patients leave the hospital, but we were not doing such a good job of making sure patients go to see their PCPs at discharge," McQuiston explains. "We know that was not happening in other areas of the hospital, from general surgery to orthopedics, and we knew there were more gaps in care transition."

Hospital leaders identified two major issues that needed to be addressed to improve the transition of care process: First, the discharge planning, case management, and social work areas in the hospital were decentralized and had no standard practices, and, secondly, there were problems with communication during care transition, she says.

McQuiston first focused primarily on the communication hand-off piece, she says.

"It was only once we got into the weeds with this that we realized our discharge process was broken, and we saw this as an opportunity to deal with that issue," she explains. "We couldn't deal with Project BOOST until we dealt with that issue."

As hospital leaders recognized the problem and determined to improve the discharge process, they hired a case manager leader who became an integral part of the Project BOOST team.

"She's been able to pull our case managers and discharge planners together around the BOOST project, and they're taking a key role in this," McQuiston says.

So far, the changes are new, but there likely will be some outcomes based on 30-day readmission rates and patient satisfaction scores available by this summer.

Here are some of the steps the hospital has taken to improve its discharge process and care transition:

• **It uses a computerized discharge process.** The computerized discharge process involves a discharge piece called DEPART, which is a work in progress, McQuiston says.

"It's an interactive discharge record that all disciplines can enter information into, and everyone can look at the record," she explains. "Also, there's a medication reconciliation piece."

The information entered in the system includes information from nursing, occupational therapy, physical therapy, case management, nutrition/dietary, and physicians.

• **DP begins on the day of admission.** "What happens now is, the case manager has variable lengths of notification time from a couple of hours to several days, and that's one of the problems we're trying to address with BOOST," McQuiston says.

"We're starting the discharge process on admission, and we're introducing daily, multidisciplinary rounds," she says.

The core group participating in rounds includes a pharmacist, nurse, case manager, and physician, but anyone else can participate as needed, she adds.

"The purpose is to give much more warning to case managers and discharge planners, so they can address all the necessary issues prior to discharge," McQuiston says. "There are several pieces, and one is to identify patients who are likely to have problems at discharge or gaps in their care."

The goal is to start addressing these issues as soon after admission as possible.

For instance, one issue the hospital has addressed involves the patient's mobility in the hospital and at home, including patients' risk for falling and home safety issues, McQuiston says. Other issues discussed are patients' social support

resources, need for durable medical equipment, and financial issues.

"Everyone who has something to contribute talks about these," she says. "If an RN knows something the PT doesn't know, then this can be communicated in the multidisciplinary rounds."

The goal is to provide staff with a format for this type of communication that is more immediate than having people write chart notes that might never be reviewed, she adds.

This method hopefully will bypass the silos in which each discipline does its own thing with too little interdisciplinary communication.

"We try to keep it efficient and complete the rounds in a timely manner," McQuiston says.

• **It sets goals and obtains buy-in.** "We elected to start this project as a pilot program with the express desire that this will be the model for how we do discharge planning and transitions across the hospital," McQuiston says. "We hope by piloting this to address barriers, because sometimes you don't know what your obstacles are."

The pilot project has obtained buy-in from staff and leaders, partly through having a nursing case manager champion the project, she adds.

Before the hospital hired a new nursing case manager, discharge planning leaders stressed to the hospital administration that it was important to have this new person involved very quickly with the discharge quality improvement project, McQuiston notes.

"So, the new nursing case manager was very supportive of all the goals of BOOST and felt she could be an advocate for the BOOST project with case managers and discharge planners on a hospital-wide basis," she explains.

"At that point, we had not decided who was going to be doing the follow-up calls, whether it'd be nursing or unit secretaries or physicians," she says. "But the new manager wanted this to be a case management piece, and she obtained buy-in on the unit for this plan."

It's been more challenging to obtain physician buy-in on the discharge planning changes, and work continues on this front, McQuiston says.

"The hospitalists I work with feel they do their piece fairly and conscientiously," she adds. "But they're often unaware of exactly what goes into making a good discharge and a good transition."

Another point is that no one wants to see his or her own workload increase.

"We've tried to sell this as a process that will not make more work for staff, but which will change the way we do things to make the process more efficient and effective," McQuiston says.

"If this is going to be successful, we cannot add another layer of bureaucracy or work," she says. "If we're going to put in something new in the process, then we'll have to take something else away, so it's really a re-engineering process."

• **It piloted changes.** Mission Hospital started a pilot project on the medical unit and have planned to add a pilot on the surgical unit, because the challenges are different, McQuiston says.

"Once we have worked out the kinks of what works and what doesn't, then we'll be ready to look at taking this hospitalwide," she says.

"What has happened is that as other units in the hospital have gotten wind of what we're doing, they've been eager to incorporate some things we're doing, and that's naturally coming about without us having to set a timeline or deadline to it," McQuiston says.

For example, the cardiovascular services have attended some meetings and have looked at making some changes based on the discharge improvements discussed there, she adds.

"We'll make all of our materials available for everyone," McQuiston says. ■

SOURCE

For more information, contact:

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Improve DP outcomes with limited resources

Optimize EMR use

What hospitalists and others involved in the discharge process truly want to do is reduce patients' risk at discharge while implementing quality improvement (QI) initiatives with limited resources.

"There is national attention on readmission and the quality of work we do to identify patients at risk, and we're doing everything we can to reduce that risk," says **Aroop Pal**, MD, assistant profes-

sor and hospitalist at Kansas University Medical College (KUMC) of the University of Kansas in Kansas City, KS. Pal also is the program director of Transitions of Care Services.

"What we're trying to accomplish in a world of limited resources is finding potential interventions that can help with those [QI] projects," Pal says. "We're identifying who is at highest risk and seeing what can be done to reduce the risk."

Whenever an organization starts a new QI project, it's a good strategy to target a unit for an intervention. So KUMC decided to screen all patients to identify those who were at high risk of readmission after discharge.

Although KUMC has become involved with Project BOOST, the goal was to screen all patients and not just older patients, Pal notes.

"From a practical standpoint, we felt all patients deserved to be screened," he adds. "We're an academic, tertiary care center with a very sick population, and we have a high case mix index and high risk for readmission."

The hospital's overall readmission rate is one out of five people within 30 days, he says.

"We felt like we had an opportunity to improve our process," Pal says. "And we implemented tools that Project BOOST provided."

Here's how the hospital implemented the QI project:

• **It set goals and a philosophy.** KUMC approached the discharge QI project with the philosophy that the hospital discharge and transition-to-care process encompasses everything that's done in the hospital from the first time a provider encounters a patient, Pal explains.

"We need to prepare the patient for the next step and give providers the information they need," he says. "So, we took the opportunity to re-examine how we do things and see if there are opportunities to improve the process."

• **It optimized electronic medical record use.** One process improvement involved using electronic medical records, which were a relatively new intervention in patient care in the hospital, Pal notes.

"We're trying to optimize the use of electronic medical records and use electronic records for discharges, including using computerized physician order entry at discharge," he says.

The QI process included re-examining the current workload and identifying better opportunities for coordinating care, Pal says.

"We've made some strides," he adds. "But the

CNE QUESTIONS

5. Which of the following educational method works better for patients at discharge?
A. Sending their families an email with instructions to go over with the patient at home
B. Reading written instructions, followed by handing these out
C. Teach-back method
D. None of the above

6. Which of the following is the type of discharge planning assessment that needs to take place when homeless or marginally-housed patients are about to leave the hospital?
A. Screening for common medical problems
B. Follow-up care access
C. Housing status
D. All of the above

7. What percentage of adult children have not done any planning for their parents' senior care needs, according to a new survey?
A. 25%
B. 46%
C. 62%
D. 73%

8. Experts say the best time to start discharge planning is when?
A. Day of admission
B. Once an acute care patient is stabilized
C. 24 hours before planned discharge
D. 48 hours before planned discharge

Answer: 1. C; 2. D; 3. D; 4. A.

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.

challenges and reality are that if [an efficient] workflow isn't in place before an EMR is introduced, then it's more difficult to implement it."

• **It provided electronic notifications.** The EMR provides electronic notification of expected discharge dates.

"That's a new field within our system that we're using to encourage providers to update regularly as information is known," Pal says. "We use the system to let nurses know the physician orders are complete."

This is more effective than the previous process, because before, there wasn't a way for nurses to be certain that all of a patient's medications had been reconciled, he notes. The way the previous process worked, the nurse wouldn't know that a physician was waiting to check on a medication dose before prescribing it, he explains.

"Now, the nurse knows when I am done with prescription orders, and the discharge instructions can be completed," Pal says. "The instructions are dependent on the orders, and if the orders are not complete, then the instructions are not complete."

• **It involved a pharmacist in medication reconciliation.** "Our administration provided a pharmacist to the unit to provide medication counseling and reconciliation," he says.

This change is on a trial basis, and data should be available soon.

"The unit surveyed patients on the value of having a pharmacist counsel them and provide a medication calendar, and patients reported being very satisfied," Pal says.

"We're trying to examine where pharmacy best can provide assistance with reconciliation because they've been proven to be valuable, but we're not yet at that point where we can afford a pharmacist for everything," he adds. "We're waiting for data to see how much of an impact it has had on the readmission rate." ■

SOURCE

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COMING IN FUTURE MONTHS

■ Experts offer updates on DP and regulations

■ Find those elusive resources for discharged brain injury patients

■ QI project targets discharge coding DRGs

■ Statewide discharge project is provider-insurer-national organization collaboration

■ Multimodal initiative improves quality of discharge documentation

FOR THE RECORD

CPT changes a start, but more could be done

The Current Procedural Terminology (CPT) code changes in place in the 2008 Physician Fee Schedule improve the ability of physicians and other providers to document their telephone evaluations and management services, but they don't go far enough, according to the Case Management Society of America (CMSA).

The current schedule includes codes related to the delivery of case management services, but these have been given a Status N, which means they are not payable by Medicare.

So CMSA is working with the Centers for Medicare & Medicaid Services (CMS) in support of providing Medicare reimbursement for these

CNE OBJECTIVES

Upon completion of this educational activity, 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.

codes.

Case managers work directly with patients in support of medical management and health care coordination, including providing health adherence assessment, education, and adherence monitoring during the discharge process.

A number of health care organizations have established or piloted programs in which discharge planners or case managers have called patients at home some days or weeks post-discharge to assess their health and continued treatment adherence. The CMS codes acknowledge the importance of such telephone services.

The three non-physician codes, issued for telephone services, include these:

• **98966**

Telephone assessment and management services provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days or leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion.

• **98967**

11-20 minutes of medical discussion during telephone assessment and management services.

• **98968**

21-30 minutes of medical discussion during telephone assessment and management services.

There are three similar codes established for telephone evaluation and management services provided by a physician.

All six of these codes are Status N, but they have Relative Value Units associated with them, meaning that private payers may cover them.

CMSA says the solution is to request funding for these six codes so providers will be able to integrate case/care managers support of the Medical Home concept, such as the Medicare Medical Home Demonstration, pay for performance programs, and various collaborative models of care which CMSA and other regulatory agencies are discussing.

For more information about this issue of CPT coding for case management, contact Michel Lee, manager of member and chapter services at mlee@acminet.com or call (501) 225-2229, ext. 1120. ■

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