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National health care reform makes discharge planning a higher priority

Think: readmissions, readmissions, readmissions

Health professionals who have worked hard to improve the discharge process might see change occur more quickly in the coming decade as the changes envisioned in national health care reform begin to take effect.

The Patient Protection and Affordable Care Act (H.R. 3590) was signed by President Barack Obama in March 2010. The new legislation appears to be nudging health care providers in the direction of improving quality, reducing lengths of stay and readmissions, and achieving optimal outcomes at a lower cost.

"For those of us in the case management and care coordination, transitions of care world, we're pretty excited about health care reform," says **Margaret Leonard**, MS, RN-BC, FNP, senior vice president for clinical services at Hudson Health Plan in Tarrytown, NY. Leonard also is the president of the Case Management Society of America (CMSA) in Little Rock, AR.

The new legislation provides funding for pilot programs that will improve care transitions and emphasize case management, care coordination, disease management, and reducing readmissions, Leonard says.

There are specific parts of the bill that address hospital readmissions, she adds. *(See sidebar on how readmissions are addressed in the bill, page 28.)*

"There's a focus on preventing the preventable hospital readmission as a key initiative in health care reform," says **Scott Flanders**, MD, SFHM, director of hospital medicine at the University of Michigan in Ann Arbor. Flanders also is the president of the Society of Hospital Medicine in Philadelphia.

Hospital medicine has grown in recent years, and communication among providers during care transitions is a particularly vulnerable area for hospitals, Flanders says.

"By necessity, there are patient hand-offs, so if there is a lack of information in the transfer or poor communication, it has potential risk for the patient," Flanders explains. "Adverse events and readmissions are among those risks."

The new health care bill will result in hospitals putting more emphasis on discharge planning and care coordination with post-acute care providers, predicts **Caroline Steinberg**, vice president for trends analysis for the

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American Hospital Association in Washington, DC.

"Hospitals will need to make sure patients are receiving more appropriate follow-up care," Steinberg says.

"In the future, hospitals will be eligible to receive higher payments if they have better performance or show improved performance on quality measures," Steinberg says. "It will result in an increased focus on patient safety and care coordination."

This shift in priority might also result in hospitals hiring more clinical pharmacists, social workers, and case managers, she adds.

Hospital leaders will need to follow the bill's regulations to determine which conditions will be the initial focus for readmission rate reduction strategies, says **Jason A. Scull**, program officer for clinical affairs at the Infectious Diseases Society of America in Arlington, VA.

Also, hospitals with abnormally high readmission rates might have their payment adjusted, he adds.

The health care reform bill likely will bring both opportunities and challenges, says **Carol Frazier Maxwell**, LCSW, ACSW, director of social work, family services, and interpreter services at the Arkansas Children's Hospital in Little Rock, AR. Maxwell is president of the Society for Social Work Leadership in Health Care in Philadelphia.

"Potentially, more people will have health care coverage, which is a good thing," Maxwell says. "But this also could mean our taxed health care systems will not be able to handle the higher volume."

And the bill will result in hospitals receiving lower reimbursement rates for some procedures, which may or may not be offset by higher volumes, she adds.

"If they're not able to increase their hiring to meet higher demand, then people will have longer waits getting into clinics, specialty programs, and that sort of thing," Maxwell says.

On the positive side, hospitals will see their charity care cases decline, as more people who previously had entered hospitals without insurance now will have health care coverage.

From a care transitions perspective, it is possible discharge planners will have an easier time finding placement for patients, since just about everyone will have some type of coverage.

Social workers and discharge planners need to convince their hospital leadership to be proactive and station someone in the emergency department to help with care transitions to non-acute care options, including long-term care facilities and other settings, Maxwell suggests.

"This is an opportunity for hospitals to look at cost-shifting," she adds. "A lot more hospitals are doing discharge planning in the ER."

The key is to have someone in place who can

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Editor: Melinda G. Young, (846) 241-4449.
Executive Editor: Russ Underwood, (404) 262-5521, (russ.underwood@ahcmedia.com).
Managing Editor: Karen Young, (404) 262-5423, (karen.young@ahcmedia.com).
Production Editor: Ami Sutaria.

EDITORIAL QUESTIONS

For questions or comments, e-mail Melinda G. Young at melindagyoung@att.net.

develop liaisons with community agencies, long-term care organizations, and other post-acute care entities.

Health care reform had been taking place even before the bill was signed in March, and hospital readmission rates have been a particular focus, Leonard notes.

"I was appointed to a CMS [Centers for Medicare & Medicaid Services] technical expert panel that was looking at readmissions within 30 days, and that's something near and dear to my heart," Leonard says.

CMS is focusing on a handful of conditions to determine whether a patient's visit with a primary care provider during that 30-day post-discharge time frame can make a difference in a hospital's readmission rate, she explains.

The AHA is concerned about the federal government's policies that could result in payment cuts to hospitals that have high readmission rates, Steinberg says.

Hospitals soon will find that they'll have to collect data about their readmission rates, and those that have unnecessary 30-day readmissions will be compared with peers. Those that are among the top 25% in having the most preventable 30-day readmissions will be penalized with reimbursement cuts.

"We're concerned that those measures may not pick up on the readmissions that are planned or unrelated to the initial admission," she says. "We're concerned that hospitals will be penalized for having readmissions that are actually appropriate, so we're advocating on behalf of our members for a fair readmissions policy."

Still, hospitals can use their discharge planning process to improve their preventable readmission rates.

"There are a lot of opportunities for care coordinators to work within a hospital system to put together a plan that shows what will keep patients from being readmitted to the hospital," Leonard says.

For example, the National Transitions of Care Coalition has developed tools that are being adopted by hospitals to help them with medication reconciliation and other aspects of discharge planning, she adds.

The new legislation puts money into care transition demonstration projects, and this also could provide opportunities for case managers and care coordinators, Leonard notes.

Also, the health reform bill establishes a national pilot program on payment bundling. The program will involve an episode of care around a hospitalization with the goal of improving coordination, quality, and efficiency of health care services.

One factor will be the number of readmissions for any of eight conditions to be selected by the Secretary of the U.S. Department of Health and Human Services.

The pilot program's goals include providing transitional care interventions that focus on a hospital inpatient episode and targeting post-discharge patient care to reduce unnecessary health complications and readmissions, according to the bill's Subtitle C - Provisions, at H.R. 3590 - 330.

In some ways, the very language of discharge planning is changing to show that all providers, including hospitals, are responsible for the patient's transition from one episode of care to another, Leonard notes.

The right questions for hospital providers to ask are whether a patient is returning to his primary care provider after leaving the hospital and whether there is some coordination of care, she says.

"The thought is that this will prevent the patient's readmission," Leonard adds.

As the health care legislation plays out, hospital discharge planners will need to focus on transitioning patients to a safe and appropriate level of care, Maxwell says.

It will be difficult to determine all the ways the legislation will impact discharge planning until the bill's regulations are written.

"The bill is here whether you liked it or didn't like it, and it's historic," Leonard says. "And now regulators need to define what the bill means, and they'll write the guidelines for what happens next."

SOURCES

For more information, contact:

• **Scott Flanders**, MD, SFHM, Director of Hospital Medicine, University of Michigan, Ann Arbor, MI. President, Society of Hospital Medicine. Email: flanders@umich.edu.

• **Margaret Leonard**, MS, RN-BC, FNP, Senior Vice President for Clinical Services, Hudson Health Plan, 303 South Broadway, Tarrytown, NY 10591. Telephone: (914) 610-0721. email: mleonard@HudsonHealthplan.org.

• **Carol Frazier Maxwell**, LCSW, ACSW, Director of Social Work, Family Services, and Interpreter Services, Arkansas Children's Hospital, 1 Children's Way, Little Rock, AR

72202. Telephone: (501) 364-6531.
• **Jason A. Scull**, Program Officer for Clinical Affairs, Infectious Diseases Society of America, 1300 Wilson Blvd., Suite 300, Arlington, VA 22209.
• **Caroline Steinberg**, Vice President for Trends Analysis, American Hospital Association, Washington, DC. Telephone: (202) 638-1100. mfenwick@aha.org. ■

Health care reform bill focuses on readmissions

The Patient Protection and Affordable Care Act (H.R. 3590) puts considerable focus on reducing hospital readmissions. Here are some excerpts and key provisions from the bill on this subject:

• By 2012, the Secretary of the Department of Health and Human Services (HHS) will develop reporting requirements for use by health plans to improve health outcomes and "implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional."

• Under Part II on consumer choices and insurance competition through health benefit exchanges (section 3590-55), there is a section on rewarding quality through market-based incentives. One of the strategies mentioned involves "the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional."

• Under section 2703, which discusses a state option to provide medical homes for enrollees with chronic conditions, there is a monitoring provision which describes "a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and (2) a proposal for use of health information technology in providing medical home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

• In section 3023, which features the national pilot program on payment bundling, there are quality measures established that include the following: "(i) Functional status improvement; (ii) Reducing rates of avoidable hospital readmissions; (iii) Rates of discharge to the community; (iv) Rates of admission to an emergency room after a hospitalization; (v) Incidence of health care-acquired infections; (vi) Efficiency measures; (vii) Measures of patient-centeredness of care; (viii) Measures of patient perception of care; (ix) Other measures, including measures of patient outcomes, determined appropriate by the secretary."

• The independence-at-home demonstration program (section 3024) makes a requirement of testing the model for accountability with these quality measures: "(A) reducing preventable hospitalizations; (B) preventing hospital readmissions; (C) reducing emergency room visits; (D) improving health outcomes commensurate with the beneficiaries' stage of chronic illness; (E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests; (F) reducing the cost of health care services covered under this title; and (G) achieving beneficiary and family caregiver satisfaction." ■

MI partnership creates new transition model

Physicians and hospitals work together

A new care transition partnership might one day be an important model for hospitals as the new health care legislation nudges providers in the direction of reducing hospital readmissions.

The University of Michigan in Ann Arbor, Blue Cross Blue Shield (BCBS) of Michigan, and 15 Michigan hospitals and physician care sites have teamed up to produce a hospital transition model that could reduce readmissions and improve care.

"In health care reform, a major area of focus is going to be improving care transitions and handoffs of patients between different care providers," says **Scott Flanders**, MD, SFHM, director of hospital medicine at the University of Michigan in Ann Arbor. Flanders also is the president of the Society of Hospital Medicine (SHM) in Philadelphia.

"This is in part to avoid potentially preventable hospital readmissions, which cost billions of dollars nationally each year," Flanders says. "Our hope is on a case-by-case, hospital-by-hospital basis, to solve this problem."

The initiative kicked off on Jan. 1, 2010, as part of BCBS of Michigan's valued partners program, says **Tom Leyden**, manager with clinical programs at BCBS of Michigan.

"We have quite a few collaborations like this, and each is a statewide collaboration of doctors, nurses, and a variety of organizations," Leyden says. "The University of Michigan serves as a coordinating center for the organization."

The initiative has a physician leader, a nurse leader, and an analyst.

"Our intent is to have an objective third-party organization to work with providers, brainstorming, and serving as a resource for physician organizations, as well as for hospitals," Leyden says. "We will help them begin or continue down the path of reducing avoidable readmissions."

Hospital providers can accomplish more through this type of collaborative when their hospital leadership is fully behind the effort.

"We certainly have major support from our hospitalist director, who is Scott Flanders, and from our CEO's office," says **Christopher Kim**, MD, MBA, an assistant professor of internal medicine in pediatrics and an assistant medical director for the faculty group practice at the University of Michigan Health System in Ann Arbor. Kim, who is closely involved in the care transition project, also is an assistant chief of staff for the office of clinical affairs at the health system.

Before the project began, the health system tried to make sure that key constituents that are critical to any chance of success were engaged in implementing this initiative, Kim adds. *(See story about how the Michigan health system targeted transition improvements, page 30.)*

Providers involved in the initiative will use tools from SHM's Project BOOST (Better Outcomes for Older adults through Safe Transitions) for all adults in primary care settings, as well as hospital settings, he adds.

"We need to target all hospitalized patients, because many who are not older adults also are at risk of being rehospitalized," Flanders says. "Project BOOST, while initially focusing on older adults, has been implemented around the country to focus on all readmissions, and not just on the elderly."

The hospitals involved in the partnership are as varied as the state of Michigan: They include rural, urban, teaching, non-teaching, large, and small hospitals, says **Della Rees**, PhD, senior health care analyst with BCBS of Michigan.

"No matter what your hospital is, the program should be accommodating," Rees says.

Each hospital has autonomy to set up its own protocols and processes to work toward the goals. However, they'll collect the same quality initiative data regarding their patient readmissions within 30 days.

BCBS of Michigan provides funding for the coordinating center, a kick-off meeting, forums, and some tools that will assist hospitals and providers in making the necessary changes and improvements.

"They can use the money in any way they choose," Rees says. "The key is collaboration among groups and analyzing current processes."

Hospital discharge leaders and others are expected to share best practices and discuss their care transition strategies at the collaboration forums.

"We provide them with the setting, the funding for a coordinating center, funding participants, some compensation to help defray costs of participation, and providing them with dashboard data, so they can drill down to investigate what their current readmissions look like," Rees explains. "It's funded through the physician incentive program, and the funding goes through physician programs."

Ideally, providers will use the funds to invest in infrastructure improvements that would have a long-term impact on care transition, Flanders says.

"The amount of resources that each physician organization will receive will not allow for large-scale projects, but it clearly will support pilot testing," Flanders says. "They'll implement these systems, and we'll see what works and what doesn't work."

Each physician organization will develop a different system by which patients are bridged from inpatient to the outpatient setting, he adds.

Discharge planners and others will collect key clinical information about patients, including their medications, diagnoses, lab tests post-discharge, etc.

"Another aspect is that hospitals will reach out to particularly high-risk patients after discharge, usually within 72 hours, to assess how things are going," Flanders says. "They'll troubleshoot par-

ticular problems and identify solutions that will be initiated on the hospital side."

There is more power in combining information and resources.

"When an individual hospital or physician organization looks at their patients, they're only looking at a small subset," Leyden says. "When you combine data with other organizations, you start to see very clear trends emerge."

BCBS has a goal of building a groundswell of activity and synergy by pulling so many providers together in one state, he adds.

"It takes a unique partnership of folks to make this work, and we find that having well-engaged physician leaders, who are well-regarded in the state of Michigan, leads to greater receptivity to what is presented," Leyden says.

These solutions likely will include a team that has physicians, nurses, social workers, pharmacists, and discharge planners working together.

"It takes a team of people working together to make this transition seamless and safe," Flanders says.

For the first part of the project, providers will collect baseline data, and they'll present this information at the initiative's kick-off meeting in mid-May, Rees says.

Society of Hospital Medicine mentors, University of Michigan experts, as well as representatives from the 15 provider groups, will attend the meeting to see which projects they'll want to tackle first.

The idea is for each hospital-physician group to select one process improvement, make that change, and follow up to assess its impact. If the process improvement works, then they'll find a way to expand its reach.

"We'll give providers an expectation of what their commitment might be, but the way each hospital operates is up to them," Leyden says. "We find we get the best results that way, because they can come back and tell others about what works."

For example, some of these types of collaborations have resulted in cost savings and outcomes improvements in transitions of care, Leyden notes.

BCBS of Michigan's data show that 10.2% of the insurer's health plan members had rehospitalizations within 30 days, Leyden says.

Of these, 63% were preventable readmissions, which amounts to $75 million in unnecessary health care costs, he adds.

"We also estimated the per patient spend for potentially preventable readmissions is $11,490," Leyden says. "That's the area we are expecting physician organizations and hospitals to address."

BCBS has other projects addressing lowering readmission rates, but this provider-insurer collaborative definitely is the future, Rees notes.

"I think this will lead to improved patient care and improved patient safety," she says. "It's not about how many dollars we save with rehospitalizations; it's about what is happening to these patients who are getting rehospitalized and fixing the cracks in the system."

SOURCES

For more information, contact:

- **Scott Flanders**, MD, SFHM, President, Society of Hospital Medicine, Philadelphia, PA; Professor, Internal Medicine, University of Michigan Medical School; Director of Hospital Medicine, University of Michigan Health System, 3119 Taubman Center, Ann Arbor, MI 48109-5376. Telephone: (734) 647-2892.
- **Christopher Kim**, MD, MBA, Assistant Professor, Internal Medicine, Pediatrics; Assistant Medical Director, Faculty Group Practice, Assistant Chief of Staff, Office of Clinical Affairs, University of Michigan Health System, 3119 Taubman Center, Ann Arbor, MI 48109-5376. Telephone: (734) 615-3036. Email: seoungk@umich.edu.
- **Tom Leyden**, Manager with Clinical Programs, Blue Cross Blue Shield of Michigan. Corporate Communications: (313) 225-9499. Email: newsroom@bcbsm.com.
- **Della Rees**, PhD, Senior Health Care Analyst, Blue Cross Blue Shield of Michigan. Corporate Communications: (313) 225-9499. Email: newsroom@bcbsm.com. ■

MI system leads in effort to improve transitions

Checklist tools, teach-back are key

Hospitals will be hearing a great deal more about care transitions and reducing readmissions in coming years. Discharge planners and hospitalist leaders will be searching for models that are affordable, effective, and sustainable.

The University of Michigan Health System in Ann Arbor is involved in a collaborative care transition project that builds on its use of Project BOOST (Better Outcomes for Older adults

through Safe Transitions) tools and strategies.

Hospitals and leaders involved in discharge planning should keep in mind that medical staff and DP staff try their best to provide high-quality care to patients, but the nature of their schedules can make communication among providers challenging, says **Christopher Kim**, MD, MBA, an assistant professor of internal medicine in pediatrics and an assistant medical director for the faculty group practice at the University of Michigan Health System in Ann Arbor. Kim, who is closely involved in the care transition project, also is an assistant chief of staff for the office of clinical affairs at the health system.

"We collaborate to ensure each patient's hospital stay is the best it can be, but when it's time for patients to leave, the process could be improved," Kim says. "This is one of the quality improvement needs that Project BOOST has helped us recognize."

Patient care transitions require input from all disciplines, including hospitalists, floor nurses, discharge planning nurses, social workers, therapists, and primary care physicians, he notes.

"But often, we're not working purposely together; we're working at our own pace and direction," Kim says. "BOOST helps us focus our efforts and energy better as we work on that particular phase of the patient's care."

Based on the health system's Project BOOST experience and its more recent involvement in the Michigan provider-insurer care transition initiative, Kim offers these suggestions for how hospitals can improve their discharge planning communication and process:

• Use a risk assessment tool to identify at-risk patients: Hospitals could develop their own risk assessment tool or select one that has been used successfully by other facilities.

Kim recommends they check out Project BOOST's 7P screening tool, which is available for a free download online at the website: www.hospitalmedicine.org.

The two-page checklist covers these seven main risk assessment areas:

- problem medications;
- punk (depression);
- principal diagnosis;
- polypharmacy;
- poor health literacy;
- patient support;
- prior hospitalization.

"These are pretty broad categories," Kim notes. "But what using the tool has helped us recognize in our own patient population is that most of our patients actually have one or more of these problems when we screen them."

• Create intervention based on findings from screening tool: "The next step is how do we engage the hospital's health care staff to address those aspects of the patient's risks?" Kim says.

The BOOST 7P screening tool includes recommended interventions under each of the risk areas. For example, the problem medications section has these checkboxes:

- medication-specific education using teach-back provided to patient and caregiver;
- monitoring plan developed and communicated to patient and aftercare providers where relevant (e.g. warfarin, digoxin, and insulin);
- specific strategies for managing adverse drug events reviewed with patient/caregiver;
- follow-up phone call at 72 hours to assess adherence and complications.

The screening tool's second page includes a 9-point universal patient discharge checklist, plus five additional considerations for increased risk patients.

"This tool helps us to ensure the patient's transition and needs have been addressed by somebody," Kim says. "It includes a look at the patient's social needs prior to going home and medication reconciliation."

The additional considerations list such items as having direct communication with principal care provider before discharge and having phone contact with the patient or caregiver within 72 hours post-discharge to assess the patient's condition, discharge plan comprehension, adherence, and to reinforce follow-up.

"In the past, we've probably recognized that the patient had one or more risk factors or needs, but how we intervened was a siloed process," Kim says. "Now, we want patients actively monitored from the get-go, and we'll have the entire team involved in the discharge process."

• Focus on education and using teach-back method: Hospital discharge planning should continually assess and improve patient education strategies.

Kim recommends using the teach-back method, which also is promoted in BOOST materials.

The teach-back concept encourages patients to actively participate and become engaged in their medication and medical condition, Kim notes.

A first step is to explain how the patient's medi-

cations have changed and listing prescriptions that are added or deleted. Then the discharge planner will reinforce what the patient already knows about existing prescriptions.

The teach-back part is when the discharge planner asks patients to acknowledge their understanding with a question like this: "We'd like to be sure we did a good job of explaining this to you. Would you mind repeating back to me what I just explained to you about your condition or medication?"

If the patient is unable to repeat the information very well, then it's an opportunity to repeat the education, Kim says.

Often when patients are readmitted unnecessarily to a hospital, the problem was that the hospital staff did not do a good job of implementing the teach-back concept, he adds.

Or, they might have used teach-back with the patient, when it would have been more appropriate to educate the patient's caregiver.

• Think outside the hospital care box when addressing patients' transition issues: The BOOST 7P screening tool includes a general assessment of preparedness (GAP) section that lists logistical issues and psychosocial issues that generally fall outside the purview of hospital medicine.

"We use the risk assessment to collect more information about patients' needs, perhaps to pick up on something we've overlooked," Kim says. "Perhaps we could have made more of an effort to speak with the patient and caregivers at home, or we could have ensured a better handoff to the primary care physician."

The screening tool's logistic issues include assessing whether the home has been prepared for the patient's arrival and whether the patient will have transportation to the initial follow-up visit. Under psychosocial issues, the tool has providers assess whether the patient's substance abuse/dependence has been evaluated and whether a support circle for the patient has been identified.

Another example of thinking outside the box involves having hospital transition planning include consideration of palliative services.

"Patients who are hospitalized multiple times for chronic diseases sometimes are deemed terminal, but they might not have the opportunity to discuss the option of consulting with a palliative care specialist," Kim explains. "Palliative care is a specialty area that could be very helpful to the patient and patient's family."

If hospital discharge providers identify patients who have had repeated hospitalizations within a six-month period, and their chronic disease status appears to be worsening, then they might suggest the patient and family speak with a palliative care specialist, he adds.

Some hospitals will make a palliative care consultation an automatic referral when such patients are identified.

• Stress collaboration: "A critical piece is how we can all work together to improve the transition phase of patient care," Kim says.

It's no longer useful for each discipline to do their part alone.

"This is why we've initiated discharge or transition care rounds where we gather together all of these disciplines," Kim says.

These rounds serve two chief purposes:

- "One, it helps everyone who may not have heard about the transition of care initiative to become familiarized with this important project," Kim says. "Transition care is gaining more prominence at many hospitals, but not everybody who works in the hospital has been introduced to the concept or to the tools that are available."

- And, secondly, transition care rounds help ensure the team identifies patients' particular needs and can assign specific disciplines to handling these, he says.

"An example is if the patient needs certain instructions in taking home medications," Kim says. "The discharge planner might facilitate handling this education." ■

BEST PRACTICES SPOTLIGHT

Follow-up calls improve patients' health outcomes

Focus is on resolving psychosocial issues

Hospital social workers using telephone follow-up of at-risk patients have made a positive impact on patient care and satisfaction outcomes, a pilot program shows.

The enhanced discharge planning program was begun as a pilot project in 2007, says **Gayle E. Shier**, MSW, project coordinator of the older adults programs at Rush University Medical

Center in Chicago.

The program is a collaboration between Rush University Medical Center's older adult programs and the case management department.

The pilot program results showed that its target population had some crucial care coordination needs.

"More than 50% of our pilot participants had some sort of ongoing need that took us more than one call to resolve," says **Madeleine Rooney**, MSW, medical center liaison for older adult programs at the Rush medical center.

The program began as a quality improvement project, but has evolved as hospital leaders learned more about this population and the impact of follow-up on their overall care and health, says Rooney, who has extensive experience in working with older adults and in hospital discharge planning.

The most common issues involved a need for follow-up on referred services, an adjustment to new illnesses or treatment, increasing dependency on others, and caregivers requiring emotional support, according to the pilot findings.

In June 2009, the hospital turned the program into a randomized, controlled study that will report Medicare data about rehospitalization rates for patients receiving the follow-up intervention vs. standard care, Shier says.

The results won't be published for a while, but so far researchers are seeing a good readmissions trend in the study, she says.

"Another thing we are seeing in the study is how we're having a positive impact on people making it to their medical appointments," Shier says. "People love this program and love that someone cares about them after they leave the hospital."

This bonding experience could be improving the hospital system's revenues by bringing back patients for outpatient care and enhancing the hospital's reputation, she adds.

The program was started as a collaboration for the purpose of promoting patient safety and quality of life and improving health outcomes. Also, its goals are to reduce unnecessary health care costs for older adults and creating a bridge between the hospital and the community.

"Our goal is to make sure the patient is stable at home and that the caregiver is supported," Shier says. "We make sure the appropriate services are started in the home, and we work to connect patients with their follow-up medical appointments."

Its discharge planning includes the development of discharge standards of care that ensure the medical team stays on track. And with social worker involvement, the program incorporates a psychosocial framework that includes finding community support for at-risk seniors.

Here's how the telephone follow-up program works:

1. **At-risk patients are identified through an electronic database.**

"We identify patients through an electronic report that stratifies their risk of rehospitalization," Shier says. "We receive a verification that patients with our risk criteria have been discharged," she says.

The referral criteria was developed from a literature review and the pilot program's experience, as well as from case manager feedback.

"Patients are leaving the hospital sooner and sometimes with more acuity than they might have had historically," Rooney notes. "For seniors, in particular, they're more vulnerable to poor outcomes for different reasons, and those sometimes include cognitive and physical limitations, social isolation, and lack of financial resources."

It is these patients who need follow-up support the most, she adds.

Patients in the program must meet all of these referral criteria:

- The patient must be age 65 or more years.
- The patient speaks English.
- The patient is returning home after discharge.
- The patient has been prescribed seven or more medications.
- The patient does not have a primary diagnosis of a transplant.

They also must meet one additional criteria, including one of the following:

- The patient must live alone.
- The patient is without a source of emotional support.
- The patient is without a support system for care.
- The patient has a high falls risk.
- The patient is discharged with a service referral.

2. **A discharge planning social worker assesses referred patients**.

The program has three primary social workers, and their caseload is dependent on the hospital's census, although typically they'll have four new patients per day per clinician, Shier says.

"They also might have other cases from previous days," she adds.

Before calling patients, the social workers will review their patients' records and case management notes for any pertinent medical and psychosocial information.

They also do the following:

• Social workers investigate patients' previous hospitalizations.

• Social workers identify potential problem areas requiring in-depth assessments.

• Social workers generate a list of questions related to potential problems.

• Social workers obtain information about the patient's situation from other providers as necessary.

3. **The social worker calls patients**.

Social workers call patients within 24 to 48 hours post-discharge from the hospital, Shier says.

The call's purpose is to perform a basic biopsychosocial assessment and to stabilize the patient's post-discharge situation. Social workers also make certain the patient will be able to follow-up with medical providers and receive all of the community services he or she needs.

During the call, social workers ask patients some specific questions about the issues identified during the patient's risk assessment and chart review.

The calls often become a means for patients to receive psychosocial support.

"An interesting thing we've found is that some patients and their families are willing to share information with us that they might not be willing to share with their doctor or nurse," Rooney says.

"Sometimes, this is because of the questions we ask people," she explains. "We often ask caregivers how they're doing, and many will laugh and chuckle and say, 'No one asks me how I'm doing.'"

4. **Develop appropriate interventions**.

Once problems are identified, social workers seek a solution. *(See case study of a patient follow-up, page 35.)*

"We look at which interventions might be associated with those problem areas and which outcomes we'd anticipate or expect," Shier says.

"The point is for us to not be the ones who will do everything for patients, but to be the ones who have the capability to connect them with people who can do more," Shier says. "And we help people follow through with their care."

Interventions often include having social work-

CNE questions

9. The Patient Protection and Affordable Care Act (H.R. 3590) focuses on which of the following areas pertaining to hospital discharge planning?
A. care coordination with post-acute care providers
B. 30-day readmissions
C. both A & B
D. none of the above

10. Which of the following risk assessment areas are included on the Project BOOST 7P screening tool checklist?
A. problem medications and depression
B. polypharmacy and poor health literacy
C. patient support and prior hospitalization
D. all of the above

11. Rush University Medical Center in Chicago has a successful telephone follow-up program for targeted patients. Social workers call patients who meet all five chief criteria and also at least one of five additional criteria. Which of the following criteria is one the patient must meet to be included?
A. The patient lives alone.
B. The patient has been prescribed seven or more medications.
C. The patient has a high falls risk.
D. The patient is without a source of emotional support.

12. Blue Cross Blue Shield of Michigan claims data show that what percentage of health plan members had rehospitalizations within 30 days?
A. 7.7%
B. 10.2%
C. 15.2%
D. 20.9%

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

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 **this** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter.

ers call the patient's primary care provider to let them know what the chief issues are and how these are being addressed.

A communication path is developed, and it works best when it goes in both directions, Rooney notes.

"It's not just having information that goes out of the health care system to the community; it's also having information that comes out of the community and back into the system," she says.

SOURCES

For more information, contact:

• **Madeleine Rooney**, MSW, Medical Center Liaison for Older Adult Programs, Rush University Medical Center, 710 S. Paulina St., Suite 427, Chicago, IL 60612-3814. Email: madeleine_rooney@rush.edu.

• **Gayle E. Shier**, MSW, Project Coordinator, Older Adult Programs, Rush University Medical Center, 710 S. Paulina St., Suite 427, Chicago, IL 60612-3814. Telephone: (312) 942-8182. Email: Gayle_E_Shier@rush.edu. ■

Case study: how discharge follow-up calls work

Patient case was challenging

A hospital discharge program that has social workers make follow-up calls to patients is designed to address patients' psychosocial needs and issues, as well as their medical ones.

"Historically we've looked at patients from a medical perspective and have minimized these psychosocial and compartmental parts of their lives," says **Madeleine Rooney**, MSW, medical center liaison for older adult programs at the Rush Medical Center.

"So, our work has been focused on providing additional support and assistance with the transition from hospital to home," Rooney says. "Also, we've been tracking over the last three-plus years the psychosocial environmental factors that impact outcomes, including where there are gaps in services and how these impact people's lives."

Here's a case study of how it works:

"We had a case of a senior, who is in her 80s, who had been in the hospital several times," Rooney says. "She lives alone, is very anxious, and has experienced over time some increased physical problems that have made it more risky for her to live alone."

However, the woman was reluctant to receive help from community services and agencies.

While she was in the hospital, she was recommended to be placed in a skilled nursing facility or to receive department of aging services if she returned home, Rooney says.

"She wasn't willing to accept those services and insisted on going home," she adds. "But when she went home, she became very anxious about not being able to manage as she had before."

The woman sometimes calls the hospital after her discharge and eventually is readmitted.

"We had intervened with her at some point in the past, and then she was referred back to us by the inpatient case management team," Rooney says. "We spent a great deal of time talking with her to try to assess exactly what it was she wanted and to find out if there was some way that she would allow us to help her."

Also, because of her age and health issues, it was imperative that the woman receive some immediate home support.

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.

COMING IN FUTURE MONTHS

■ Cardiac care improvement is focus of hospital's DP

■ Tele-intensive care unit focuses on reducing readmissions

■ Hospitals can begin discharge planning in the emergency room

■ Medical home model can include DP collaboration

■ DP program's focus on medication reconciliation pays dividends

"We were trying to prevent a crisis that would result in her returning to the emergency department unnecessarily," Rooney says.

The social worker also called the woman's primary care physician and orthopedic physician, who treated her following hip surgery.

"We asked them to agree to our recommendation, which basically was to convince her to accept some home health services," Rooney says.

The woman had been resistant to this type of help all along, but after telephone conversations with the social worker, she changed her mind.

"We got some orders in place for her to receive nursing care in her home," Rooney says.

The woman was at risk for falling, so she would also be eligible for physical therapy. And the discharge program social worker put the patient in touch with a home health care social worker to further address her psychosocial issues.

"This is where our connections come in," Rooney explains. "We recognize the limitations of our services, because they're telephonic; and we're obviously not able to be there in the home with her."

With the physicians' input, they formulated the most cohesive and best possible plan to prevent the patient from having a crisis, to stabilize her situation, and to get her to agree to home care services, she adds. ■

FOR THE RECORD

Check CMS website for readmission comparisons

Hospitals will need to get used to the idea of reporting their 30-day readmission results as the new health care reform bill expands on this initiative of the Centers for Medicare & Medicaid Services (CMS).

In addition to published reports of hospital 30-day mortality rates, CMS features 30-day readmissions measures for patients who were originally admitted to the hospital for heart attack, heart failure, and pneumonia.

The information is available to consumers at www.hospitalcompare.hhs.gov.

CMS uses a model that is based on claims data and has been validated by clinical data models to assess hospital readmissions and mortality rates. The model takes into account medical care received during the year prior to each patient's hospital admission, as well as the number of admissions at each hospital.

For the period of July, 2005, to June, 2008, CMS reports that 19.9% of patients nationally with acute myocardial infarction were readmitted within 30 days of hospital discharge; for heart failure patients, the national data show a 24.5% 30-day readmission rate, and for pneumonia, the 30-day readmission rate was 18.2%. ■

DISCHARGE PLANNING
ADVISOR

DPA060110TM

PLEASE NOTE: If your correct name and address do not appear below, please complete the section at right.

Please make label address corrections here or PRINT address information to receive a certificate.

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CNE Evaluation: Please take a moment to answer the following questions to let us know your thoughts on the CNE program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your certificate.**

CORRECT ● **INCORRECT** ⊘ ✓ ✗ ⚠

1. If you are claiming nursing contact hours, please indicate your highest credential: ○ RN ○ NP ○ Other _____

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
After participating in this program, I am able to:						
2. Identify particular clinical issues affecting discharge planning.	○	○	○	○	○	○
3. Apply discharge planning regulations to the process of discharge planning.	○	○	○	○	○	○
4. Describe how the discharge planning process affects patients and all providers along the continuum of care.	○	○	○	○	○	○
5. Cite practical solutions associated with the discharge planning process based on independent recommendations from clinicians working in the field or from specific regulatory bodies.	○	○	○	○	○	○
6. The test questions were clear and appropriate.	○	○	○	○	○	○
7. I detected no commercial bias in this activity.	○	○	○	○	○	○
8. This activity reaffirmed my clinical practice.	○	○	○	○	○	○
9. This activity has changed my clinical practice.	○	○	○	○	○	○

If so, how? _____

10. How many minutes do you estimate it took you to complete this entire semester (3 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers to the correct ones listed. _____ minutes.

11. Do you have any general comments about the effectiveness of this CE program?

_____

I have completed the requirements for this activity.

Name (printed) _____ **Signature** _____

Nursing license number ***(required for nurses licensed by the state of California)*** _____

Discharge Planning Advisor

2010 Reader Survey

In an effort to learn more about the professionals who read *DPA*, we are conducting this reader survey. The results will be used to enhance the content and format of *DPA*.

Instructions: Fill in the appropriate answers. Please write in answers to the open-ended questions in the space provided. Return the questionnaire in the enclosed postage-paid envelope by **August 1, 2010.**

In future issues of *DPA*, would you like to see more or less coverage of the following topics?

A. more coverage B. less coverage C. about the same amount

1. clinical pathways	O A	O B	O C
2. discharge planning strategies	O A	O B	O C
3. outcomes management	O A	O B	O C
4. regulatory issues	O A	O B	O C
5. continuum-of-care issues	O A	O B	O C
6. dealing with physicians	O A	O B	O C
7. staffing and caseloads	O A	O B	O C
8. communication among caregivers	O A	O B	O C

Please rate your level of satisfaction with the following items.

A. excellent B. good C. fair D. poor

9. quality of newsletter	O A	O B	O C	O D
10. article selections	O A	O B	O C	O D
11. timeliness	O A	O B	O C	O D
12. length of newsletter	O A	O B	O C	O D
13. overall value	O A	O B	O C	O D
14. customer service	O A	O B	O C	O D

15. On average, how many people read your copy of *DPA*?

O A. 1-3
O B. 4-6
O C. 7-9
O D. 10-15
O E. 16 or more

16. How would you rate your overall satisfaction with your job?

O A. very satisfied
O B. somewhat satisfied
O C. somewhat dissatisfied
O D. very dissatisfied

17. How would you describe your satisfaction with your subscription to *DPA*?

O A. very satisfied
O B. somewhat satisfied
O C. somewhat dissatisfied
O D. very dissatisfied

18. What is your title?

O A. case manager
O B. manager/supervisor/director
O C. social worker
O D. discharge planner
O E. other_____

19. How large is your hospital?

O A. fewer than 100 beds
O B. 100-200 beds
O C. 201-300 beds
O D. 301-500 beds
O E. more than 500 beds

20. *Discharge Planning Advisor* has been approved for 7 nursing contact hours using a 60-minute contact hour by the American Nurses Credentialing Center's Commission on Accreditation. If you participate in this CNE activity, how many hours do you spend in the activity each year? _____

21. Do you plan to renew your subscription to *DPA*?

O A. yes
O B. no If no, why not? _____

_____

Please indicate yes or no for all of the areas for which you are responsible in your facility or system.

22. discharge planning ○ A. yes ○ B. no
23. social work ○ A. yes ○ B. no
24. utilization management ○ A. yes ○ B. no
25. quality improvement ○ A. yes ○ B. no
26. other (please specify) _____

27. What is the highest degree that you hold?

- ○ A. ADN (2-year)
- ○ B. diploma (3-year)
- ○ C. bachelor's degree
- ○ D. master's degree
- ○ E. other_____

28. To what other publications or information sources about discharge planning do you subscribe?

29. Including *DPA*, which publication or information source do you find most useful, and why?

30. Which web site related to your position do you use most often?

31. Please list the top three challenges you face in your job today.

32. What do you like most about *DPA*?

33. What do you like least about *DPA*?

34. What are the top three things you would add to *DPA* to make it more valuable for your money?

Contact information