DISCHARGE PLANNING
ADVISOR

July/August 2010: Vol. 3, No. 4
Pages 37-48

IN THIS ISSUE

Financial Disclosure:
Editor Melinda G. Young, Managing Editor Karen Young, and Executive Editor Russ Underwood report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor/Nurse Planner Toni Cesta discloses that she is principal of Case Management Concepts LLC.

Medical home model can be complementary to hospital DP

Model has point person for DP to call

A health care model that seeks to improve quality while reducing costs is attracting more attention lately as the health care reform has made it a priority for pilot project funds.

The patient-centered medical home (PCMH) model, also called simply "medical home," takes medicine back to a previous time with patient care that is focused around a primary care physician (PCP) team structure. The idea is that patients treated in medical homes have their care coordinated by one PCP, who handles all referrals and ancillary care.

The medical home model could avoid 25% of current readmissions, saving $25 billion a year under a scenario in which it's used nationwide, according to a recent Microsoft Health Plan Industry Group monograph on the subject.

"The tenet of the medical home model is the patient would have a quarterback, a relationship with a personal physician and health team that would help navigate the patient through our complex health care system," says **Marjie Harbrecht**, MD, CEO of Health TeamWorks, formerly the Colorado Clinical Guidelines Collaborative (CCGC) of Lakewood, CO. Health TeamWorks is a nonprofit collaborative that is working to redesign the health care delivery system.

"More importantly, it should keep them healthy and out of the system," Harbrecht says.

From a hospital's perspective, the model ideally will reduce unnecessary hospital utilization, because it will prevent emergency department visits by patients with diabetes, congestive heart failure, or heart disease that is poorly maintained, Harbrecht and other experts say.

"The hospitals agree they don't want to give inappropriate care," Harbrecht says. "They want the appropriate care where it should happen: right time, right place, right care."

The medical home model's goal is to provide continuous, coordinated, comprehensive care for the purpose of improving quality and reducing costs, she adds.

In the siloed, uncoordinated health care system prevalent in the United States, patients see whichever providers they desire, making frequent changes, and no one provider knows everything about the patient's health status.

"Patients can go wherever they want, but no one helps them coordinate

AHC Media LLC

care," Harbrecht explains. "So, the patient might show up in the ER with a condition that could have been treated in a lower-cost setting."

Currently, nationwide, 13% of hospitalized patients require readmission within 30 days of being discharged, and one of the chief causes is delayed or inaccurate communication between hospitalists and primary care physicians around discharge, according to the Microsoft Health Plan Industry Group paper.

The medical home model seeks to reverse this trend, having patients think to first call their medical home office, which often provides after-hours access to a care coordinator, when they have a problem.

The model isn't a gatekeeping system like the old HMO model of the 1980s, says **Wanda Hanson**, RN, MSN, quality and chronic disease manager of Sanford Health - MeritCare in Fargo, ND.

"If the primary care provider (PCP) can treat the patient's diabetes, then that's where we want it treated," Hanson says. "If they're having difficulty, then it's very important to refer to the endocrinologist, and it's the same for cardiology and other specialties, as well."

It's difficult to say precisely how the medical home model will impact a particular hospital, because each type of medical home is handled differently, the experts say.

For example, each medical home patient seen at one hospital after a congestive heart failure (CHF) diagnosis will receive education and follow-up telephone calls from a nurse specialist, says **Tina M. Snapp**, RN, BSN, CCM, continental division director of case management at Hospital Corporation of America in Denver.

Case managers also can provide discharge care.

"They make sure they have someone in the case management department who is coordinating care to make sure primary care visits are made in the first week of discharge, which is a significant factor in readmissions," Snapp says. "It's amazing how many people who don't have a PCP visit billed after hospital admission are readmitted."

Ideally, the medical home model leads to better communication and hand-offs between providers.

"We now have a home health provider that has very good discharge programs, risk assessments, disease management programs that we, in essence, will be handing off to," Snapp says. "So, we're creating a streamlined discharge process where the home care coordinator or liaison will see the patient before the patient leaves and within specific intervals, including within 24 hours of discharge."

The goal is for the program to make sure high-risk patients are receiving support when they first return home and perhaps for the first 30 days post-discharge, she adds.

With the medical home model, this process includes the continuation of patient education in

Discharge Planning Advisor (ISSN# 1940-8706) is published every other month by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304.

POSTMASTER: Send address changes to Discharge Planning Advisor, P.O. Box 740059, Atlanta, GA 30374.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 7 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 7 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 7 clock hours.

This program was approved by the National Association of Social Workers (provider # 886399925) for 7 continuing education contact hours.

This activity is valid 36 months from the date of publication.

The target audience for Discharge Planning Advisor is social workers, case managers, and nurses.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST. World Wide Web: www.ahcmedia.com. E-mail: customerservice@ahcmedia.com.

Subscription rates: U.S.A., one year (6 issues), $199 Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $78 each. (GST registration number R128870672.)

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.

the home setting and sending information and updates to the PCP office.

"We want to make sure we're all bridged in this, because we know communication is one of the biggest downfalls of this whole process," Snapp explains. *(See story on how discharge planning best works with medical home model, below.)*

One of the drawbacks of the medical home model is that hospitals receive no financial incentives to provide better care coordination and communication, some experts note.

"The money still goes to the physician, so the devil is in the details of this," says **Robyn Golden**, MA, LCSW, co-founder of the National Coalition on Care Coordination in New York and director of older adult programs at Rush University Medical Center in Chicago.

"There are no expectations for the hospital," she adds. "It's the medical home where the expectations sit."

Still, there is potential for a good fit with medical home PCPs and hospitals, she notes.

"The medical home has a transition component of making sure people get more integrated into the community and never are admitted in the hospital in the first place," Golden says. "So, there's great potential for case management and a bundled payment."

Some states have moved forward on the medical home model, using it for Medicaid patients or mandating its availability for all insured patients.

For example, the state of Minnesota passed legislation in favor of the model. The medical home rule went into effect on Jan. 11, 2010. Clinics certified in the medical home model will receive a fee per member per month for coordinating care, Hanson says.

Also, in North Carolina, the medical home model is used to improve health care outcomes among Medicaid patients who have chronic illnesses.

There are nearly 1 million Medicaid recipients in North Carolina, and there are 14 nonprofit networks that serve as their medical home, says **Denise Levis Hewson**, RN, BSN, MSPH, director of clinical programs and quality improvement for Community Care of North Carolina in Raleigh, NC.

These medical homes take care of sick Medicaid patients, but also look for people who have undiagnosed or untreated chronic diseases to provide them with disease management services, Hewson says.

"They hire care managers, who work with the highest-risk and highest-cost patients to bring them disease management," she explains. "They follow them when they come out of the hospital, help with their medications, and make sure the medical home has the information and data needed to manage their population."

For example, the medical home works closely with diabetes patients, following evidenced-based practices, such as having the physician examine patients' feet for numbness, which could signal diabetic neuropathy, leading to insensitivity, ulceration, and even amputation.

"Research shows that if patients come into the exam room and don't take off their socks and shoes, then the physician doesn't see their bare feet or think about examining their feet," she says. "So, the medical home staff make sure the patient's feet are easily accessible and noticeable when the doctor conducts the exam."

SOURCES

- **Robyn Golden**, MA, LCSW, Co-Founder, National Coalition on Care Coordination in New York, Director of Older Adult Programs, Rush University Medical Center, 710 S. Paulina St., Suite 422, Chicago, IL 60612-3814. Telephone: (312) 942-4436. Email: Robyn_L_Golden@rush.edu.
- **Wanda Hanson**, RN, MSN, Quality and Chronic Disease Manager, Sanford Health - MeritCare, Fargo, ND. Email; wanda.hanson@meritcare.com
- **Denise Levis Hewson**, RN, BSN, MSPH, Director of Clinical Programs and Quality Improvement, Community Care of North Carolina, 2300 Rexwoods Drive, Suite 200, Raleigh, NC 27607. Email: dlevis@n3cn.org. Telephone: (919) 745-2363.
- **Marjie Harbrecht**, MD, Chief Executive Officer, Health TeamWorks — formerly Colorado Clinical Guidelines Collaborative (CCGC), 274 Union Blvd, Suite 310, Lakewood, CO 80228. Email: info@healthteamworks.org. Website: www.healthteamworks.org.
- **Tina M. Snapp**, RN, BSN, CCM, Continental Division Director of Case Management, Hospital Corporation of America, 4900 South Monaco St., Suite 380, Denver, CO 80237. Email: tina.snapp@healthonecares.com. ■

Medical home model helps DP process with care

Point person or EMR keeps all providers informed

Here's a common hospital discharge scenario: the patient is ready to be discharged home, and the hospital has a discharge planner or case

manager who is prepared to call the patient's primary care physician (PCP) to discuss the patient's post-discharge care. But who does the discharge planner call? And will anyone respond to the call?

"Everyone in a typical doctor's practice is busy; and they might be a little annoyed, because they don't have time for this; and they don't have a system in place to handle it," says **Marjie Harbrecht**, MD, CEO of Health TeamWorks, formerly the Colorado Clinical Guidelines Collaborative (CCGC) of Lakewood, CO.

This is where the patient-centered medical home model can greatly benefit discharge planning. With this model, there is a person to call — a primary care case manager or care coordinator. And chances are that the care coordinator might even call the hospital discharge planner first.

"The medical home sets up a specific contact system, so each person has been assigned to someone who can check this log to see who has been in the hospital and emergency room," Harbrecht says.

The hospital discharge planner can tell the medical home coordinator about the patient's discharge, the hospital team's chief concerns, and the need to have the patient seen by a provider soon after he or she returns home, she adds.

Harbrecht and other experts discuss these ways the medical home model can enhance care transition and the hospital discharge process, and how hospitals can make the most of these transitions with or without assistance from medical home providers:

• Create tools to improve communication between the hospital and medical home/PCP.

Physicians sending patients to the hospital will want to communicate some specific details about the patient's case, but it's often unclear how they might do so, Harbrecht notes.

"Who is the patient, his or her demographics, histories, medications, allergies, etc.?" she says. "And how do you contact me and send information back?"

Also, there might be times when the PCP doesn't know the patient has entered the hospital, and the hospital doesn't know where to send results.

TeamWorks created some tools to help with these communication issues.

One is a wallet card for medical home patients. They receive a handout that says, "You're now part of a medical home, and here's what it means; here's how to reach us after hours, and if you do have to go to the ER, call us first to see if we can help you through that," Harbrecht says.

Patients keep these cards in their wallets or purses, so they'll have it to show hospital staff their PCP's name and their health coordinator's name and contact information.

Another tool is a fax referral form that is available for these care transitions:

- PCP to hospital - direct admit;
- hospital to PCP;
- PCP to ED;
- ED to PCP.

These one-page fax forms have spaces for all essential communication about the patient, including the following information:

- patient name;
- patient date of birth;
- dates of hospitalization;
- hospital name;
- attending physician/hospitalist;
- reasons for hospitalization;
- discharge diagnoses;
- key lab/imaging results;
- new medications/immunizations;
- procedures done;
- pending lab/imaging results;
- recommended follow-up (including specialists contacted);
- comments;
- provide discharge summary if available.

• Provide electronic communication processes.

"One challenge is how to get succinct communication back and forth between the busy emergency department and the primary care physician and back," says **Tina M. Snapp**, RN, BSN, CCM, continental division director of case management of Hospital Corporation of America of Denver.

One method is to provide PCPs with access to the hospital's computer system and electronic medical records for their patients.

This way they can check their patient's lab test results at the time they have the patient sitting in the exam room waiting for them.

"Through our information system, we set up a remote access for the physician group, so they can go online for information," Snapp says. "We have a website called healthonecares.com, and doctors can go online with access codes, and if these are tagged to their patient, they can see the test results."

Insurance company nurses also can access this system when they're primary payers, she adds.

• Work with medical home care coordinators.

Medical home care managers provide complex case management for patients, Snapp says.

"From the discharge perspective, we know the primary care office, and we can call different care coordinators in the offices, and information will go over to them," she says.

"It's set up in our system that discharge summaries and information is faxed over to the primary care office too," Snapp says. "So, they know what happens in the course of hospitalization."

It can be a relief to hospital discharge planners to have a point person to call about a patient.

"It's still our responsibility, but the difference is we have somebody to call and say, 'This person is very high risk and has been here several times, so would you please make sure you get the patient in your office right away,'" Snapp explains.

"Before, you might call the doctor's office and leave a message that goes into oblivion," she adds. "But now, there's someone at the doctor's office who's responsible for this call, and that's a huge difference."

Case managers and social workers have a tremendous opportunity to be a positive force in care transition through the medical home model, notes **Robyn Golden**, MA, LCSW, co-founder of the National Coalition on Care Coordination in New York City and director of older adult programs at Rush University Medical Center in Chicago.

Medical home care coordinators regularly call patients to make certain they are adherent to their medication and doctor visits and to see if they have any symptoms that might lead to an ED visit.

"They talk to patients all the time, making sure things are going okay," Golden says. "They're the contact person."

SOURCES

• **Robyn Golden**, MA, LCSW, Co-Founder, National Coalition on Care Coordination in New York, Director of Older Adult Programs, Rush University Medical Center, 710 S. Paulina St., Suite 422, Chicago, IL 60612-3814. Telephone: (312) 942-4436. Email: Robyn_L_Golden@rush.edu.

• **Marjie Harbrecht**, MD, Chief Executive Officer, Health TeamWorks — formerly Colorado Clinical Guidelines Collaborative (CCGC), 274 Union Blvd, Suite 310, Lakewood, CO 80228. Email: info@healthteamworks.org. Website: www.healthteamworks.org.

• **Tina M. Snapp**, RN, BSN, CCM, Continental Division Director of Case Management, Hospital Corporation of America, 4900 South Monaco St., Suite 380, Denver, CO 80237. Email: tina.snapp@healthonecares.com. ■

Physicians use checklists for quality DP

Tool helps hospitals meet national quality measures

Mistakes happen even to the best clinicians. This is why hospitals increasingly are relying on checklists and other tools to assist clinicians in the discharge process.

One such tool, called a clinical decision support system, is an electronic checklist that enables hospital clinicians to meet all safety and quality goals every time they make a patient discharge.

The tool can assist hospitals with meeting quality measures used by the Hospital Quality Alliance (HQA) and Hospital Quality Incentive Demonstration (HQID) project.

A study comparing clinician compliance with heart disease treatment quality measures before and after use of an electronic checklist found significant improvement from the pre-intervention period to the post-intervention period. Clinicians' compliance with delivery of discharge instructions increased from 37.2% to 93% for acute myocardial infarction.[1]

Overall compliance with the cardiac discharge measures improved with the use of the clinical decision support system from 76.8% in the pre-intervention period to 96.8% in the post-intervention period.[1]

"It's not like a doctor ever wants to do the wrong thing, but you need another safety mechanism to assure 100% quality," says **Jeff Riggio**, MD, MS, physician advisor for information systems in the department of medicine, division of hospital medicine at Thomas Jefferson University Hospital in Philadelphia.

"We've realized the need to have systems in place, and having this as a computer-aided system has been helpful," Riggio says.

The hospital instituted the checklist for discharge planning involving cardiac patients with the help of a staff focus group and physician leaders, he says.

The movement toward using checklists partly is drawn from the airline industry, which instituted such processes to improve safety, he notes.

"The airline industry has translated many of its initiatives to improve quality and safety, and now we're taking advantage of their experiences," Riggio adds. "We're taking up their recommendations and adapting them for health care use."

Hospitals already have access to best practice guidelines. For instance, the Centers for Medicare and Medicaid Services (CMS) and the Hospital Quality Alliance have national quality initiatives. And various cardiac societies also have national guidelines involving cardiac care.

"So, we know what appropriate care is for our patients," Riggio says. "Unfortunately, to err is human, and people forget things; so we need a computerized system to help us achieve better compliance."

Electronic checklists can be useful tools for all clinical staff involved in the discharge process, including medical students, nurse practitioners, and attending physicians.

They works by having a section called the national quality measures section pop up on screen whenever a clinician keys in a specific diagnosis relevant to these measures.

"Once the appropriate diagnosis has been selected, there is a required checklist that needs to be performed before you can complete your documentation for the patient," Riggio explains. "You're forced to say whether or not you've prescribed an ACE inhibitor or given the patient appropriate discharge instructions."

The electronic system requires clinicians to answer a few questions before the discharge instructions are finalized.

"It takes an extra two minutes, if that long," Riggio says. "It's a mandated checklist. And for heart failure patients, there are two questions; and for acute myocardial infarction patients, there are four questions."

For a specific diagnosis, the electronic system will list patient instructions. These include having patients weigh themselves daily, follow their prescribed diet, know their activity recommendations, and understand their medication instructions.

"The program will require you to put in a follow-up post, and the program will have specific instructions for heart failure patients, talking about what to do if symptoms get worse and how to monitor weight," Riggio says. "This is automatically included in what's printed out for the patient."

Physicians can use their desktop computers to create the discharge instructions, which are all Web-based and available on the hospital's intranet, he adds.

"We're looking at putting computers in every room, but that's in the future," Riggio says.

One of the big mistakes that an electronic checklist can prevent involves whether or not physicians have reminded patients to take aspirin or prescribed an ACE inhibitor, he notes.

"For heart failure patients, the electronic prompt will remind them that the patient needs to be on an ACE inhibitor," Riggio says. "It reminds the discharging physician, because sometimes the discharging physician is not the physician who took care of the patient the entire time."

These continual hospital hand-offs are windows in which mistakes can occur, so the checklist is helpful in making sure the necessary communication occurs.

"It helps to double-check on prescriptions," Riggio says. "The physician might say that when the kidney function is better, we'll start an ACE inhibitor, and this will remind them to prescribe the drug."

The checklist also provides transparency in hospital care, and it's printed out and given to patients, who can see the quality measures for themselves. The total discharge instructions might be five pages with headers and page breaks; they're self-explanatory, listing medications and instructions about when to call a doctor. There are icons highlighting the various sections.

"Patients will be aware of quality standards for their disease process," Riggio says. "Patients often are never involved or see the end result; but we actually give them a copy of it, because this is one of the few documents we give patients routinely."

Some physicians and hospitals might debate the wisdom of sharing this information with patients, but from Riggio's perspective, it is the right move: "We felt this was the future [of medicine], to empower patients and have them understand these decisions we're making."

Typically, the physician will review the instructions with patients, although nurses might also be involved, Riggio says.

The other benefit to sharing the information is that the patient can take it to his or her community physician, who now will know why particular drugs were prescribed or not prescribed, he adds.

"Copies of these discharge instructions also could be sent to outside referring clinicians," he says.

The electronic checklist could be used by various health care systems as a means to improve clinical decision support at discharge.

"We've been working on rolling this out at an affiliate hospital in South Philly," Riggio says. "It has translatability to many different systems and hospitals."

REFERENCE

1. Riggio JM, Sorokin R, Moxey ED, et al. Effectiveness of a clinical-decision-support system in improving compliance

with cardiac-care quality measures and supporting resident training. *Acad Med*. 2009;84(12):1719-1726.

SOURCE

• **Jeff Riggio**, MD, MS, Physician Advisor for Information Systems, Department of Medicine, Division of Hospital Medicine, Thomas Jefferson University Hospital, 833 Chestnut St., Suite 701, Philadelphia, PA 19107. E-mail: jeff.riggio@jefferson.edu. ■

Hospital uses service for follow-up calls

Patient satisfaction rises

Calling patients after hospital discharge is a good quality improvement and patient satisfaction strategy, but it is often difficult to implement because of resource restraints.

San Juan Regional Medical Center in Farmington, NM, found a solution that has worked well for its facility: using an outside contractor to make the calls.

"We had our own in-house call center, and the nurses who did the Ask A Nurse line made the follow-up calls," says **Catherine Zaharko**, vice president of marketing at San Juan Regional Medical Center. "But there were a number of reasons why that wasn't working," Zaharko says. The chief problem was the hospital couldn't keep the nursing coverage it needed for the call center because of a nursing shortage in the region.

"So, we contracted out for the Ask A Nurse line, and we asked them to do the discharge follow-up calls, too," Zaharko says.

This provided consistency for the services. The Ask A Nurse line could be operated on a round-the-clock basis, and the discharge follow-up calls were reliably made within 24 to 72 hours post-discharge.

The discharge calls help the hospital identify areas that need improvement and help provide care continuity and safety to patients once they've left the hospital.

Patient safety is the top priority, Zaharko notes.

"We want to know if the patient is OK, if patients are taking their medications, if patients have someone at home to help them if they need assistance." she says. "The most important thing is patient safety."

These post-discharge calls also can have the side benefits of reminding patients to see their community physicians and identifying obstacles to their continuing medical stability, she adds.

"We can identify other things that might make it difficult for the patient to follow their discharge instructions and maybe find ways to help the patient be more compliant and avoid a readmission or emergency room trip," Zaharko says.

Another benefit is the information can help the hospital identify trends.

"Is transportation a problem for people in our community after discharge? Is access to 24/7 pharmacy an issue?" she says. "We could find a way to address these issues."

First, the hospital had to change its questions to make them more specific.

"We had been asking a lot of questions we thought were pretty soft," Zaharko says. "So, we changed our survey to make it far more specific: 'Do you have transportation? Do you know how to use your medications?'"

For example, San Juan Regional Medical Center has identified two trends from the discharge follow-up calls. The first involved whether or not patients could identify who their nurse was vs. other caregivers, Zaharko says.

"We found that patients did not distinguish between caregivers," she explains. "So, we put a new process in place, so that the patient does know who the nurse is."

A second trend involved hand-washing.

"We found that patients and their families were not aware when caregivers washed their hands upon entering or leaving their room, so we began hand-washing instructions by caregivers to patients to raise awareness," Zaharko says.

From the hospital's perspective, the post-discharge calls work, because these are seen by patients as a seamless part of the hospital's health care service.

"We will make a call to a patient who has been discharged from the hospital or emergency room within 24 to 72 hours after their stay," says **Mark Williard**, senior vice president, product management, at Beryl Company of Bedford, TX, which provided the post-discharge calls for San Juan Regional Medical Center.

"We look to see if they were satisfied with the services they received, how they were treated by nursing staff, and what they thought of their room and food services," he says. "We also give them an opportunity to highlight any good services they have received, such as a particular nurse who

treated them well."

Hospitals use the kudos to recognize staff members found to be doing an especially good job.

These first calls are made by non-clinicians, but they can result in a referral to a nurse if a problem is discovered, Williard says.

Called "escalations," these complaints might result in the call center staff notifying a nurse or the hospital for follow-up calls or treatment, he adds.

If something arises, typically it will occur in the first 24 to 72 hours, so if a patient has a fever that won't go away or a new pain or some new condition that wasn't apparent at discharge, then nurses escalate those back to the hospital for treatment, he says.

"We find that fewer than 2% of all calls wind up with an escalation, so it's not a huge issue for the hospital," Williard says.

Often, a patient might need more information or have a minor complaint, and all of these are transcribed and recorded for the hospital to review if necessary.

"These would be issues that do not need to be handled right away," Williard says. "Emergency service issues are rare, but on every call we have information that will help with future changes in care."

The call service also provides a second type of call — called a clinical call — that is made by a nurse, also within 24 to 72 hours post-discharge, he adds.

"These are placed to higher acuity level patients and to those with higher risk of readmission," Williard says. "With those calls, our focus is on trying to identify whether patients have a situation that could lead to a readmission."

Hospitalists at San Juan Regional Medical Center identify patients at risk for readmission, and then all of these patients are called post-discharge by a non-clinician, Zaharko says.

The patients are asked these questions:

- How do you feel today?
- Have you gotten your prescription filled?
- Are you taking your medication as prescribed?
- Do you understand your discharge instructions?
- Did you make an appointment with your primary care physician?

At San Juan Regional, the patient calls are escalated to a hospital nurse if there are any medication or other clinical questions, Zaharko notes.

"We want those kinds of calls escalated to our clinician, so we can identify if we're being clear enough with our discharge follow-up instructions," she adds. "We want to make sure our nurses are providing enough information for the patient."

Other health care facilities may choose to have a contractor's call center nurse handle those calls.

"Our nurse is logged into the medical record of the client, and so if the patient has any questions about the discharge, then the nurse can clarify those for the patient," Williard says. "We accept this call for those facilities that have electronic records, but we have faxed solutions for those without an electronic record."

As increasing numbers of hospitals move to electronic medical records (EMR), the discharge follow-up process will be more seamless, Williard predicts.

"Our vision is that anything that happens on this call will go on an EMR, so there will be a history of all points of care, including what happens on the discharge call," he says.

The post-discharge services result in higher patient satisfaction, according to data Beryl collected as part of pilot studies. In one case, the survey showed that patients who were called after discharge reported satisfaction with their hospital stay 76.4% of the time vs. 72.5% for patients who had not received the call.

On some measures, the difference was more striking. For instance, when asked if nurses listened carefully to them, patients who received the post-discharge call expressed satisfaction 81% of the time, vs. 69.1% for those who did not receive the call. Also, when asked whether the staff did everything to help with the patient's pain, patients who received the post-discharge call were satisfied 83% of the time vs. 75.2% for those who did not receive a call.

Post-discharge calls to patients are the right strategy and should be routine, Williard says.

"One of our clients said, 'You know, I get a call from the vet after my pet has been seen, and it's the right thing to do after our patient has been seen,'" he says. "Discharge calls can provide a warm touch and collect any information that might improve care."

SOURCES

• **Mark Williard**, Senior Vice President, Product Management, Beryl Company, 3600 Horward Road, Bedford, TX 76021. Email: mark.williard@beryl.net.
• **Catherine Zaharko**, Vice President of Marketing,

San Juan Regional Medical Center, 801 W. Maple St., Farmington, NM 87401. Telephone: (505) 609-2000. ■

Provide better ED discharge planning

Use resources to assess home environment

The health care system benefits when unnecessary hospital admissions are avoided, and sometimes the best place to impact that trend is by focusing discharge services on the hospital emergency department (ED), an expert says.

"If you can avoid an admission in the hospital, it's good for the patient, as well as for the health care system," says **W. June Simmons**, CEO of Partners in Care Foundation in San Fernando, CA. The nonprofit organization focuses on innovations in delivery-system design through early intervention and prevention.

One way it's good for the hospital is that many patients who use the emergency room for care are the same patients who lack adequate health care resources, as well as community support. So, they might become a compassionate care admission to the hospital, simply because hospital providers do not know where else to send them, Simmons notes.

"Hospital [providers] don't know what to do with these patients and will admit them to the hospital, even though they probably don't need an acute care level of care," Simmons says. "Admitting these patients to an acute care hospital is an expensive and sometimes a risky move for patients, because it's better for people to avoid hospitalization whenever they can."

What are needed are new models for ED discharge and hospital discharge planners who help providers improve these transitions.

"If a social worker could mobilize immediate private duty care in the home, then an ED patient could be discharged home," Simmons says. "Or the hospital social worker could help a patient transfer to a psychiatric unit or some other alternative site."

These types of ED discharge planning need to be explored, she adds.

Hospitals need to look more closely at an integration of community resources and mental health resources when working with care transition of ED patients, Simmons says.

"Some people say 80% of care for chronic conditions occurs in the home, so you have to mobilize the community," she explains. "Transitions are all about making sure someone who has a health challenge or frailty challenge remains at home safely and makes maximum use of the medical care offered to them."

This includes extending hospital/ED discharge planning to environmental assessments. For instance, someone should make certain patients have the necessary wheelchair ramps, elevated toilet seats, and other home adjustments needed to accommodate someone with limited mobility and chronic health issues.

Patients who are admitted to the hospital after an ED visit, or who are frequent fliers in the ED, often have home environment issues such as an untidy home, improper nutrition, floor tripping hazards, low lighting, substance use, or medication complications, Simmons says.

A hospital discharge planner should know of community resources that might assist with making a home environmental assessment or visit.

Other questions discharge planners should ask about patients are as follows:

- Does the patient have access to food and a safe environment in the home/community?
- Does the patient have transportation to community providers?
- Does the patient have access to medication and any necessary assistance with taking drugs?

This last issue is very important, because older ED patients discharged home often have multiple chronic conditions and a variety of medications to take. Plus, they might have several different doctors who each see only one part of patients' health picture and do not communicate with each other, Simmons says.

Another issue is whether the ED patient has Medicaid or some other payment system that will cover in-home care management.

"The Medicaid waiver is Medicaid with permission to provide ongoing care management in the home," Simmons explains. "You can buy things Medicaid usually doesn't cover like heavy-duty cleaning, putting in ramps and grab bars, and bringing in someone to give the patient a bath."

If patients can't find reimbursement for these services that might make it possible for them to stay at home, then they likely will be ED frequent fliers and end up hospitalized or transitioned to a nursing home for the long term, she adds.

"We've been looking at the Medicaid waiver program in California, and we've found that

almost 50% have flagged up on electronic screening for medication alerts," she says. "These patients have signs and symptoms that might reflect a medication problem, including dizziness, confusion, and a history of recent falls."

Half of these patients had a combination of conditions and medications that would suggest the need for a pharmacist to review their medication history, and more than one-third of the patients had medical problems that needed to be brought to the attention of their doctor, Simmons says.

One of the most common problems is therapeutic duplication, in which patients are on three different medication prescriptions, and all of the drugs are in the same class, Simmons says.

"In the Medicaid waiver program, the care manager goes into the patient's home and does a complete assessment, looking at all medications," she adds.

"We developed an electronic system for screening for patients who have concerns, and then a pharmacist reviews these to see if there is a problem," Simmons explains. "So, medication reconciliation is a huge issue in discharge planning."

Discharge planning that spans the hospital continuum, including the ED, likely will be a more common practice as the Patient Protection and Affordable Care Act of 2010 results in philosophical and, eventually, payment shifts in the national health care industry, she predicts.

The Centers for Medicare & Medicaid Services (CMS) has already begun aligning incentives by announcing that it won't pay hospitals for readmissions within 30 days of certain medical conditions, Simmons notes.

Plus, health care reform bill's emphasis on prevention and evidence-based programs will drive a lot of the change.

"There is a whole lot of effort and resources being put into finding better ways of delivering care, and all of these efforts are promising to help us look for something that is more tailored to address where people fall out of the system and close these gaps," Simmons says.

If patients have medical crises, often the root cause of their emergency is related to inadequate discharge planning, she adds.

The goal is to provide rapid follow-up care when patients are transitioned from the ED or hospital to home — and then to assess their situation and follow them closely, Simmons says.

"We need to put the resources in place to keep them stable at home and provide good continuity

CNE questions

1. What percentage of current hospital readmissions could be avoided, according to a recent expert monograph?
   A. 13%
   B. 18%
   C. 25%
   D. 39%

2. Which of the following is an advantage to using an electronic discharge checklist for cardiology patients?
   A. The checklist can provide transparency in hospital care.
   B. The checklist can be printed out and given to patients.
   C. The checklist lists medications and instructions for calling doctors.
   D. All of the above

3. According to discharge planning experts, which of the following would not be a good question to ask recently discharged hospital patients in a follow-up telephone call?
   A. Have you gotten your prescription filled?
   B. Are you feeling nauseous, and would you like to return to the emergency room to be checked?
   C. Did you make an appointment with your primary care physician?
   D. Are you taking your medication as prescribed?

4. Which of the following is a chief benefit of the medical home model from a hospital discharge planning perspective?
   A. The medical home model saves the nation in health care costs.
   B. The medical home model usually entails having a care coordinator in the primary care office working with the hospital and other providers to help with hospital-to-home and other care transitions.
   C. The medical home model results in better care coordination and communication across providers.
   D. Both B and C

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

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

with their medical care," she adds.

SOURCES

For more information, contact:

• **W. June Simmons**, CEO, Partners in Care Foundation, 732 Mott St., Suite 150, San Fernando, CA 91340. Telephone: (818) 837-3775, ext. 102. Email: jsimmons@picf.org. ■

What does DP do at patient EOL?

Care continuity still necessary, expert says

Hospitalized patients with terminal illnesses often feel abandoned by their physicians at the end of their lives. Their physicians might experience a lack of closure that is unsettling.

While no physician plans to abandon a dying patient, this often is what happens, particularly when the patient's crisis leads him or her to the hospital.

Here's a case study example: a 72-year-old woman entered a hospital emergency room with complaints of acute pain caused by metastatic cancer. The woman had no family in her Arizona community, and she was admitted only after she claimed to be unable to care for herself at home. Her community physician was out of town and unavailable.

The hospital provided treatment for her pain and begins to prepare for surgery, but it was soon discovered that the cancer is too widespread to warrant surgery. The hospital prepared to discharge the woman to a cancer specialty center that could identify the origin of her cancer, but the patient declined this transfer, saying she did not want to be transferred for further tests and could not withstand the pain or take care of herself if she were sent home.

Meanwhile, the patient expressed feelings of anger and abandonment by her physician and the hospital. The physician did not interrupt his vacation to check on her condition after she was hospitalized, and, from her perspective, the hospital seemed eager to get rid of her.

The solution ended up being a transfer to a residential hospice center that had inpatient, acute care beds. The woman's Medicare benefit paid for the acute care stay, and the woman did not live long enough to be discharged back to the community.

This type of situation is all too familiar to oncologists and other physicians who try to help patients make an end-of-life transition, according to a study about abandonment of patients at the end of life.[1]

"The main finding of our study was that although physicians were conscious of not abandoning their patients at the end of their lives, the patients still could be abandoned because they were sent to hospice and there was no follow-up by the doctor," says **Anthony Back**, MD, a professor of medicine at the University of Washington, Fred Hutchinson Cancer Research Center and a gastrointestinal oncologist at Seattle Cancer Care Alliance in Seattle, WA.

"At the time of the patient's death, the patient might not hear from the physician, and that led family members to feel like they had been abandoned," Back says. "Physicians said it felt like a lack of closure for them, but they didn't recognize

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

- Reduce unplanned rehospitalizations
- Improve patients' adherence to DP instructions
- Process improves quality of DP documentation
- What predicts prescription problems post-discharge

the effect it had on their patients."

For example, one family member interviewed by researchers was crying and saying, "Gee, I know he's busy and has lots of patients, but we had been through so much together that I was surprised we didn't hear from him at the time of death," Back recalls.

"The physician said, 'I was out of town when the patient died, and when I got back in town I wasn't sure if I should call because I might stir things up,'" he says. "It was a little poignant. The doctor wouldn't have stirred things up, but he could have helped the spouse heal a little by acknowledging her grief and everything they had been through together."

Clearly, when dying patients are transferred from the hospital to hospice care, the hospital and hospice nurses will do a good job of ensuring a smooth transition, Back notes.

"But it's not always clear to the patient how much the physician is involved," he adds.

What the study shows is that patients are very attuned to how doctors and nurses think of them as regular people, as human beings, as opposed to just diagnoses, Back explains.

"So, it's incredibly important to us that we make sure we're respectful with that part of our relationship, and we need to learn how to integrate the biomedical part of our work with the humanistic part of our work," he says.

From a hospital discharge planning perspective, it's important to automatically follow up on patients who are transitioned to hospice care, Back says.

Someone should assist them with making an appointment to see their community physician, which helps them return to a regular routine in their lives.

"It's very powerful for patients, and it's an easy thing to do," Back says.

"The other thing I would recommend is that when a provider finds out someone has died, then he or she should call the family member and ask how things went," he adds. "You can express whatever seems authentic to you, like, 'I appreciate how hard you worked on behalf of your husband, wife, son, daughter.'"

REFERENCE

1. Back AL, Young JP, McCown E, et al. Abandonment at the end of life from patient, caregiver, nurse, and physician perspectives: loss of continuity and lack of closure. *Arch Intern Med*. 2009;169(5):474-479.

SOURCE

• **Anthony Back**, MD, Professor of Medicine, University of Washington, Fred Hutchinson Cancer Research Center; GI Oncologist, Seattle Cancer Care Alliance, 825 East Lake Avenue East, Seattle, WA 98109. ■