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IN THIS ISSUE

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Health care providers need to think outside the box to reduce readmissions

Look at community, payers for answers

Health care systems that lack quality improvement projects to reduce their readmission rates or fail to discuss utilization issues with private payers, third-party administrators (TPAs), and others already are stuck in 20th-century thinking and habits, experts say.

The future is here, and it involves hospitals, physicians, employers, insurers, TPAs, and governmental or nonprofit groups working together to keep their region's populace healthier and out of the hospital. One of the crucial parts of this objective is the goal of reducing hospital readmission rates, experts say.

"Historically, health care centers have rewarded doctors for volume, and hospitals got paid again when patients were readmitted," says **Guy D'Andrea**, president of Discern Consulting in Baltimore. D'Andrea was scheduled to speak about transitions of care and pay-for-performance at the National Business Coalition on Health's annual conference, held Nov. 14-16, 2010, in Washington, DC.

"It's not that they were actively seeking to have patients readmitted, but they didn't focus on building systems that would reduce readmission rates," he says. "This is particularly true in transitions of care, where the doctor and hospital are separate entities and get paid separately, leading to a system that is fragmented."

The future can be found in what a few health care leaders are doing: building coalitions that address health care transitions from a holistic, community perspective, he says.

Evidence suggests that preventable readmissions are frequent, and readmitting patients is far more expensive than investing the time and effort into preventing readmissions, says **Jeremy Nobel**, MD, MPH, adjunct lecturer on health policy and management at Harvard School of Public Health in Boston.

This is why the Centers for Medicare & Medicaid Services (CMS) and corporations are beginning to pay more attention to health care transitions.

For instance, the Affordable Care Act of 2010 includes cost-containment strategies that address reducing hospital readmissions. The act states that it will reward hospitals that successfully reduce avoidable readmissions. The regulations are expected to be issued in 2011. Also, the government website

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Hospital Compare (www.hospitalcompare.gov) will report readmission rates.

Corporations are following suit and seeking ways to align financial incentives for providers to reduce readmissions, D'Andrea says.

There are a number of different models being proposed that will promote integration and coordination of care across multiple health care settings, he explains.

One model is pay-for-performance, which is also called P4P, he adds.

"That's where the business tells the provider, 'Here's what we expect you to do when the patient is discharged,'" D'Andrea says.

Employers will expect providers to take these steps at discharge:

- Review patients' medications to make sure patients are on the right medicines and won't take any that lead to adverse health events.
- Follow-up with them periodically post-discharge to make sure they do what they need to do.
- If they have a health need, build that into the plan.
- Lower the readmission rate as an end goal.

In exchange, the payer will provide physicians and hospitals with financial incentives for positive outcomes and quality performance.

With the health care reform bill, it is more likely that discharge planning strategies and tools will become widely used by health care systems.

"There are different models and payment mechanisms out there for people to try," says **Michael Ong**, MD, PhD, assistant professor at the University of California — Los Angeles (UCLA) David Geffen School of Medicine.

UCLA has led the formation of a consortium of UCLA's medical schools, plus Cedars-Sinai Medical Center in Los Angeles to research the use of wireless and telephone care management to reduce readmissions of heart failure patients. Ong is the principal investigator of the research. (*See story on wireless care management, page 65.*)

"As evidence becomes clear that these methods are effective, there might be some means of making sure people are compensated for the services they provide," Ong says. "If these approaches are demonstrated to be effective and can reduce costs further, then people will look to implement them."

The current system's methods for handling discharge do not work, so it will take changes and different incentives to improve the process nationwide, Ong adds.

"Under any payment structure, if you can provide effective services at a low cost, then those are the things that will be adopted," he says.

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Payers will check readmission rates and other quality indicators to see how hospitals are progressing with the necessary changes.

"When we talk about hospitals, the readmission rate is the key outcome indicator," D'Andrea says. "In other clinical areas, there might be other outcomes we will look at."

Hospitals will need to put more resources and staff in discharge and care transition planning, if they expect to achieve the results that will help them make the grade with Medicare and payers, experts say.

One recent study found that hospital nurses and other staff spend too little time with patients at discharge, says **Mark V. Williams**, MD, FACP, FHM, chief of the division of hospital medicine at Northwestern University Feinberg School of Medicine in Chicago.

Williams was one of the researchers who worked on a project that evolved into Project BOOST, a national project that promotes better quality care transition planning. Dozens of health care systems have adopted Project BOOST initiatives and have used BOOST tools.

"The study found that less than 10 minutes was spent at discharge process," he adds. "This didn't surprise me, because this [is] how it's typically managed: Patients are told what to do and then asked if they have questions, and then the discharge process stops."

When hospitals give discharge planners time to make certain patients truly understand their instructions, it can pay off in multiple ways, Williams says.

"Patients are really pleased when someone takes the time to confirm they understand, because too often the discharge process is rushed," he says. "Also, nurses are pleased by this; one nurse told us after we implemented Project BOOST in her hospital that this is why she went into nursing."

The discharge process can be confusing with inadequate patient education — even for patients who have advanced health literacy skills, says **Terry Davis**, PhD, professor of medicine and pediatrics at the Louisiana State University Health Sciences Center at Shreveport, LA.

Davis saw firsthand how difficult it is to interpret medication instructions and other directions on the discharge form sent home with patients after she had mitral valve surgery, followed by a hospitalization. (*See Davis' story about patient's perspective, page 66.*)

"When I was discharged, I was overwhelmed," Davis says. "I was being discharged with so many medicines [that] I didn't know the indications for the medicines, and why I was taking them, or how long I'd be taking them."

Discharge planning tools that provide templates with clear written instructions for patients could help prevent this type of confusion. While these have not been widely implemented to date, experts expect that will change.

Now that the health care reform bill clearly promotes better discharge planning and is expected to result in financial rewards for reduced readmissions or penalties for frequent-flier patients, many hospitals are scrambling to implement discharge tools, Williams says.

"Prior to this, there was no financial incentive and even a disincentive to manage discharge properly," he says. "If a patient was discharged, and bounced back in one to four weeks, that was another payment to the hospital."

From the non-Medicare payer perspective, it will be difficult to focus on financial incentives that address only the hospital piece of the care transition process, Nobel notes.

"If you expect commercial payers to have fees available to reward discharge planners, then you have to think about how it will help the whole patient population," he explains. "You would have to focus on not just the discharge planning process, but the environment in which you are discharging patients."

The receiving environment needs to be prepared and coordinated, he adds.

"There is no better example than preventable readmissions to illustrate how health care delivery is a system with care established between groups," Nobel says. ■

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Use evidence-based tools to improve discharge

Expert points to Project BOOST

One strategy hospitals can employ to improve their readmission rate is to use evidence-based tools and processes at discharge.

Project BOOST tools are one place to start, says **Mark V. Williams**, MD, FACP, FHM, chief of the division of hospital medicine at Northwestern University Feinberg School of Medicine in Chicago. Williams was one of the researchers who worked on a project that evolved into Project BOOST.

"Not only does BOOST present an evidence-based tool kit that hospitals can use, it also engages the hospital through mentored implementation," Williams says. "We have an experienced hospitalist who is knowledgeable in transitions of care to guide a team at the hospital to implement the BOOST tool."

One tool Williams helped to develop is a patient discharge tool that is designed with language that is very accessible to the layperson.

"Instead of writing the diagnosis of heart failure, the tool has you write, 'I have the following medical problems,' and 'While in the hospital I had these tests performed, which showed this,'" he explains.

Here are other features on the discharge patient education tool:

• It lists patient's admission date, discharge date, and days in the hospital.

• The patient's doctors' names are listed, along with their specialties; the hospitalist's number is listed, as well.

• Under the section of "Diagnosis," there are notes written after these three statements: "I had to stay in the hospital because," "The medical word for this condition is," and "I also have these medical conditions."

• Under the "Test" and "Treatment" sections, there are tables for writing multiple tests and conditions.

• The treatment section states, "While I was in the hospital I was treated with ____"; "The purpose of this treatment was: ____".

• The top of the second page lists information about follow-up appointments, and there's a place for the patient to put his or her initials before the statement, "After leaving the hospital, I will follow up with my doctors."

• The follow-up appointment section includes places to list the primary care physician's and the specialist physician's names, phone numbers, and dates and times of appointments.

• Under "Follow-Up Tests," the patient again places initials before the statement, "After leaving the hospital, I will show up for my tests"; This is followed by a brief table listing tests, location, date, and time.

• A final section, called "Life Style Changes," asks the patient to initial this statement: "After leaving the hospital, I will make these changes in my activity, and diet"; It leaves one line for activity and one for diet, and each are followed by an answer to the question "because."

• There also is a subsection for smoking that has the patient check if he or she is a nonsmoker or list a plan for quitting if the patient is a smoker.

• Then there is space for a date and time when the patient will receive a follow-up phone call, followed by the patient's signature and doctor or nurse case manager's signature, along with a date.

• The bottom of the second page of the patient education tool also lists phone numbers for the patient to call if he or she has any problems or questions after leaving the hospital.

• The third page has one brief section on medications, stating, "When I leave the hospital and go home, I will be taking the medicines on my prescription form." This is followed by these four statements which the patient must initial:

— I understand which medicines I took before I came to the hospital and will now STOP.

— I understand the medicines I will continue taking and new medicines I will take.

— I understand why and when I need to take each medicine.

— I understand which side effects to watch for.

• Finally, the tool states: "Please bring all of your medicines to your follow-up appointments."

The tool provides a pathway that presents only essential information for the patient.

"Instead of 25-30 pages of materials, which find their ways to wastebaskets or to folders that are never opened, it gives patients the information they need to manage their care," Williams says.

For instance, the three-page tool does not include a number of items that should be included in the discharge summary, including these:

• key findings and test results;

• condition at discharge, including functional status and cognitive status, if relevant;

• discharge destination and rationale;

• all pending labs or tests, responsible person

who will receive the results;

• recommendations of any sub-specialty consultants;

• documentation of patient education and understanding;

• resuscitation status and any other pertinent end-of-life issues.[1]

In addition to using a patient discharge instruction tool, discharge planners should use the teach-back strategy with every patient.

"What's critical is if you're teaching a patient about a procedure they must do themselves, like administering insulin . . . that you have them demonstrate that procedure to you," Williams says.

Or discharge planners should ask the heart failure patients to explain why they should weigh themselves daily, he adds.

So, the discharge nurse or social worker might say, "I want to make sure I've done a good job of educating you about this, so I'm going to check," he says.

Then ask them who they are supposed to call for follow-up care, he says.

"As we demonstrated in earlier research, standardized appointment slips are hard to understand for some patients," Williams says.

Also, hospital discharge teams should call patients within 48 to 72 hours after discharge with appointments scheduled within one week of discharge, he adds.

"Get the discharge summaries completed within 24 hours of discharge, and make sure all medications are reconciled," Williams says. "You need to make sure the patient knows how to recognize all signs and symptoms and exacerbation of disease."

REFERENCE:

1. Halasyamani L, Kripalani S, Coleman E, et al. Transition of care for hospitalized elderly patients – development of a discharge checklist for hospitalists. *J Hosp Med.* 2006;1(6):354-360. ■

Consortium hopes to reduce readmissions

Key is use of wireless management

As health care reform has directed national focus to finding ways to improve public health and cut medical costs, leading hospitals, providers, and others are seeking ways to improve care transitions.

As part of this effort, a consortium of hospitals in California recently received a $9.9 million federal grant to study the use of wireless and telephone care management of heart failure patients. The goal will be to reduce hospital readmission rates and overall medical care utilization.

"I think the main impetus for us getting started in this area is looking at variations of health care outcomes across the medical center," says **Michael Ong**, MD, PhD, an assistant professor at the University of California — Los Angeles (UCLA) School of Medicine, and the principal investigator involved in the three-year project.

The consortium includes five University of California medical schools and Cedars-Sinai Medical Center. They'll work together to enroll patients in a randomized control trial with three arms, including one arm for standard care.

"With health care reform, there's a lot of interest in reducing overall utilization," Ong says. "We've looked at certain types of existing interventions shown to improve those metrics."

Examples include the transitional care model developed by **Mary D. Naylor**, PhD, RN, and another such model developed by **Eric A. Coleman**, MD, MPH, he notes.

"One thing we had seen from these models is that while they may be cost-effective from the payer's perspective, they had a low adoption rate because of the cost of doing these types of interventions," Ong says. "We were looking to find interventions that could be effective and reduce overall cost in terms of utilization and implementation."

Researchers found there is existing literature on using remote monitoring as a way to improve care, but reduce overall program costs, he adds.

"Having structured telephone monitoring can be a substitute for some things you can get from a home care visit," he says. "We were interested in testing out ways to adapting these types of approaches that would be more feasible for implementation."

The federally funded study will enroll patients who are 55 years and older and have been hospitalized for heart failure. Investigators selected this population because of its association with high readmission rates, Ong says.

"We know that there is a likely failure in terms of what happens after they get discharged because of the high rate of these patients being rehospitalized within 30 days," he explains. "Half do not have an outpatient visit before being rehospitalized, so somewhere along the way, we don't get them back in care as needed."

The study will look at two types of interventions, including a structured telephone monitoring

call that uses a basic home phone and a remote monitoring approach, using wireless devices placed in people's homes.

"We have a centralized call center that worked for all six medical centers rather than one for each medical center, which reduces costs and duplication," Ong says. "It's run by nurses who conduct structured telephone interviews."

Nurses, who likely will be at the level of advanced practice nurses or nurse practitioners, will question patients about their heart failure symptoms and medical issues. For the first 30 days post-discharge from the hospital, nurses will speak with patients at least once a week, and after that there will continue to be structured calls for up to six months, he says.

The call center will be operated weekdays during working hours, so patients will be instructed to call for emergency help if they have problems during the evening or weekend hours.

"We will be reaching out to patients to make sure they're on track, but it's not a substitute for their usual care," Ong notes. "If we're substituting for their actual care system, then that's defeating the purpose."

The call center nurses will ask patients about their scheduled visits with community providers and assist them with making appointments when necessary.

The second intervention will collect data about patients' compliance with discharge instructions, such as checking weight and blood pressure. The remote monitoring device is a Bluetooth device that includes a central device plugged into the home's telephone jack. It uses a digital scale to transmit information back to the call center. It also asks patients to respond to a half dozen standard "yes or no" questions daily. These address symptoms, such as shortness of breath, Ong explains.

"If they're not sending information back, then someone will call them," he adds.

The wireless monitoring device also sends data from a special weight scale and a blood pressure monitoring device. So, each time patients use these tools, the results are sent to the call center, where they can be analyzed, Ong explains.

"If there are certain parameters exceeded, it will trigger a warning," he adds. "Then, the centralized call center will call the patient to ask, 'How are you doing? We noticed your weight has been increasing over the last several days. Have you had any changes in your diet, or is there a problem with your medications?'"

The call center nurse will help the patient troubleshoot and get into the right kind of care to address the problem.

"What we were looking at is you could do structured telephone contact with people, but probably not every patient needs that," Ong says. "So, if you have a way of monitoring patients to make sure they're not running into trouble, then we can tailor resources to address the people who need them most, and that will reduce overall costs."

Investigators will study the enrolled patients' rehospitalization rates within 30 days and 180 days, as well as overall costs, mortality rates, and quality of life, based on standard surveys.

"We know that each of these six medical centers have tried out various approaches, and certain things were effective, but targeted to smaller groups of the heart failure population and not to everyone," Ong says. "We're expanding it to help all heart failure patients." ■

DP can seem confusing, scary to patients

Medications were not explained well

Health care professionals working in the area of hospital discharge planning might find that the most effective way to understand how patients perceive their communication is to go through the process themselves.

While it's not practical to hold discharge drills for hospital staff, they could learn a little from the experience of an educated professional who has far higher than average medical literacy skills.

"I've done health literacy research for years," says **Terry Davis**, PhD, professor of medicine and pediatrics at the Louisiana State University Health Sciences Center at Shreveport, LA.

"Then, several years ago, I had an experience I would not have expected, since I'm a full professor and faculty member of a medical school; and I have adequate literacy skills," she says.

Davis was discharged from a major and well-reputed academic medical center after mitral valve surgery.

From the start of the discharge process, she was confused about her medications. Previously, she had been prescribed no medications, and now she was being sent home with a lengthy and perplexing list.

"When I found out what the medications were for, I was still confused about why they put me on those medicines," she says. "For instance, I was

put on a high blood pressure medicine, but I don't have high blood pressure."

Also, she was discharged with a medicine to treat her stomach, but she didn't have stomach problems.

"Another medicine's instructions said to take it once a day, but it didn't say how long to take it," Davis says.

Davis had an important question about whether she was supposed to be taking warfarin, which she had been given without any instructions, making her wonder if it had been an accident. The charge nurse she called checked electronic records and could not find Davis' name in the computer, so she was unable to give her any specific information or advice.

"I had just had surgery and felt weak and vulnerable," Davis recalls. "I asked her to help me make this decision, and all she could say was, 'We usually give this at night.'"

Davis was given a water pill called furosemide, but no one gave her instructions about watching for swelling in her ankles.

When Davis called her internist to inquire about how she was supposed to take one of her medications and whether she was supposed to fill one prescription, her doctor told her that she had to call the hospital. When she called the hospital, the person she spoke to said to call her internist.

"I was a professor who had been in many grand rounds; I'd done research in plain language communication, and I was still overwhelmed," Davis says. "I think physicians often know how to diagnose the problem, and they know the best evidence for a treatment plan, but they don't know how to embed that in your life."

Instead of receiving help at a critical transition point in her medical care, Davis was left to interpret the discharge instructions and medication list on her own. (*See story on strategies for improving DP instructions, page 68.*)

"When I got home, I had to figure out how to take the medicine," she says. "I didn't have a strategy; for instance, the Lipitor and Coumadin looked alike, and I couldn't remember which one I'd taken."

While she experienced post-discharge pain and weakness, she could not interpret how to take her pain medications correctly. The instructions said to take one or two tablets of Percocet every two to four hours. Then it also said to take Tylenol every six hours, as needed, for pain. Both drugs contain acetaminophen, which Davis found out from her own research several years later.

"I found out there were two things of concern about pain medication," she explains. "First, how did I space them out, or did I take them together? Second: Which Tylenol did I take, because there are many different kinds?"

She also learned that Percocet has 320 mg of acetaminophen, and the Food and Drug Administration (FDA) had ruled that people should not take more than six of those in 24 hours because of the potential for liver damage.

Before doing her own research, Davis did not know that by taking both Percocet and Tylenol she could potentially put herself in danger of an overdose of acetaminophen.

"I didn't realize I had to pay attention to the active ingredient in the prescription of an over-the-counter drug," she says. "Most people don't pay attention to an active ingredient."

Other medication issues made her adherence difficult: Davis found that the plastic pill container's cap kept breaking off, and she had trouble refilling prescriptions, because they were staggered to be available at different times.

"Providers are not aware of the burden to the patient," Davis says.

"No matter how well-educated or how seemingly experienced you are, if you have been discharged from the hospital, you will experience a certain amount of vulnerability," Davis says.

When Davis speaks about her experience as a patient to a room full of physicians, pharmacists, and others, she often sees stunned faces. Once a pharmacist told her that when pharmacists are involved in discharge planning, they go over every medication with patients to discuss how they are taken and how to avoid taking more than what is safe at any given time.

One of the more perplexing parts of her experience was the contrast between the pre-surgery patient care and education vs. the post-discharge care and education.

"Pre-surgery education was fantastic," Davis says. "Every doctor I saw and every test was so well-coordinated and done in one day."

It ran smoothly. The surgeon met with her for an hour and answered all of her questions, and explained in terms she could understand how the surgery would solve her medical issues.

By contrast, her discharge nurse quickly breezed through the patient teaching.

"She completely lost me," Davis says. "I looked down at the sheet she gave me, and it was single-spaced with tons of words; and I said, 'Can you write down what these are for?' and she was put-out by that request." ■

Best practice strategies can improve DP

Expert refers to personal experience

There are multiple small ways and steps hospitals can take to improve their patients' discharge instructions and care.

The teach-back method is one practical and simple way to confirm a patient's understanding of discharge instructions, says **Terry Davis**, PhD, professor of medicine and pediatrics at the Louisiana State University Health Sciences Center at Shreveport, LA.

Davis suggests these other strategies for improving the discharge process:

• **Make patient discharge papers more user-friendly.** Hospitals can improve their patient education materials for discharge by making them simpler. They can do this by giving people exactly the medical information they need, such as which drugs they'll be taking and why, and how they'll [take] these, Davis says.

"People need health information that is accurate, accessible, and actionable," she adds.

Davis has seen some excellent examples of this, including one discharge sheet that showed illustrations of breakfast, lunch, dinner, and bedtime accompanied by a list of medications that would be taken at any of these times in the day.

"These instructions had everything a patient would need to know, and it did this in Chinese, Spanish, and English," Davis says.

• **Design a discharge program from the patient's perspective.** "Ask patients what they need to know," she says. "After patients tell you what they need to do, put it down on paper with plain language and pictures and test it out to see if it was helpful."

Hospitals should initiate a program with oral and written communication components.

The written component should have space between sentences and illustrations when applicable.

"It needs to be broken down and be shown with charts," Davis says.

The oral component should be interactive, with the discharge nurse asking patients questions about which drugs they're taking and which times of the days they'll be taking them, she says.

The discharge nurse also could help patients figure out how to incorporate their new medication regimen into their daily lifestyle by asking them how they store their medications — and when they are most likely to remember to take them, Davis says.

For instance, discharge nurses could teach patients to take their medicine at breakfast and dinner, their cues to establishing this habit.

• **Have someone available to answer questions post-discharge.** Some hospitals call this a "warm line," meaning it's not the number patients call for actual emergencies, but a number to call when they have minor symptoms or do not understand their discharge instructions.

This doesn't have to be a line that is continuously manned, but there should be concerted effort to have these patient calls returned within 24 hours.

"I like the idea of a warm line, because the teachable moment is when you have the problem," Davis says. ■

Good data come from internal discharge system

Coding system identifies systemic issues

Once a health care system decides to improve its discharge planning process, the difficult next step is collecting information about what doesn't work and how to improve flawed processes.

Stony Brook (NY) University Medical Center developed an internal coding system that has worked well as a solution to this dilemma.

"We decided that in order to address and make some more global and executive-level decisions, we needed to know the barriers to discharge," says **Catherine Morris**, RN, MS, CCM, CMAC, executive director of care management at Stony Brook University Medical Center.

"We might have a gut feeling that the discharge problem involved insurance, or a behavioral issue, or family issues, but we didn't have any way to quantify that, so we put together barrier codes and tracking codes," Morris explains.

The coding system has worked well, highlighting systemic barriers, according to Morris.

Once this systemic barrier was identified through the coding system, the hospital began to work on finding a solution.

Since the hospital's census remains at 98%, there is a continual supply of patients needing beds. This means the hospital's overall financial health benefits from providing care more effi-

ciently and making timely discharges.

Since installing the discharge barrier coding system nearly three years ago, the hospital's average length of stay (LOS) initially decreased, but eventually remained level at about five days.

"Without this system, the LOS would be worse, because our census has included more difficult cases in recent years," Morris says. "We have a lot more uninsured patients."

"There definitely are millions of dollars in revenue to be generated as we get better and better at quantifying what are the barriers that hold patients in the hospital," Morris says.

Here's how the discharge coding system works:

• **Develop coding barrier categories**. Stony Brook uses five different categories for the barriers, including the following:

— acuity level divided into 1a, 1b, 1c, etc.;
— community resource issues;
— patient or family issues;
— financial or insurance issues;
— medical team.

For example, if the patient is given an acuity code, then it means the patient has acute needs that require hospitalization, and this is what is keeping them in the hospital longer than expected. A category 1a acuity code refers to a patient who is too clinically sick to be discharged, Morris says.

A 1b acuity code refers to patients who might need suctioning every one or two hours, and there are no local, sub-acute facilities capable of handling such a patient, she adds.

"So, we would talk with a respiratory therapist and look for things that could be done, such as re-evaluating the patient," Morris says. "Sometimes we cannot do anything except track the issue."

Another acuity code might refer to patients who are receiving care in the intensive care unit (ICU), although they do not need an ICU level of care.

This might occur because the medical team is delayed in downgrading the patient's care, or there is indecision because the team cannot agree on a discharge plan, Morris says.

When this barrier is identified, the solution might be to have the physician advisor see the patient and assist in decision-making.

• **Develop tracking coding categories**. Each patient is given two barrier codes and two tracking codes.

"We have eight tracking codes, which are end-stage renal disease, mentally disabled, psychiatric patients, child protective services, undocumented patients, expensive treatment, alternative level of care, and expensive treatment," Morris says.

Since initiating the coding system two years ago, they've added and fine-tuned codes. For instance, the tracking code related to expensive treatment was added when this issue popped in the data, she adds.

"We have people with normal insurance, but the drug they're on is equal to or more than their daily insurance rate," Morris explains. "So, we can't send them to a nursing home, because the drug is so expensive; and we can't send them home, so they end up staying in the hospital."

• **Meet regularly with staff to discuss discharge codes, issues**. "We have weekly meetings with staff to get a real understanding of what's going on with the patient," Morris says. "Representatives from finance and managed care, directors of the departments, including the director of case management and social work, the medical advisor, nursing management, and I meet to discuss what's going on with the patient."

They talk about patients' barriers to discharge and how these can be addressed and resolved.

"The staff discusses what's going on with the patient's activities, discharge barriers, and other problems," Morris says. "Then, the director and I sit together with the staff to make a final decision about the codes."

Supervisors can select codes for patients, but the discharge team can change these.

"We do some reliability testing to make sure everyone is defining things in the same way and thinking the same way," Morris says. "We make sure it's valid, and that everyone is coding the same way."

For instance, the finance representative might help the patient apply for Medicaid if the main barrier involves insurance and family income issues.

In cases of patients who are undocumented and who need sub-acute care that's not available for them in the United States, the hospital team might look into resources in the patients' home nations or arrange for the patients' families to come and take care of them.

"We might have a social worker meet with a family that is estranged and redevelop that tie with the patient," Morris says. "Or, we might need to work with a facility about receiving charity payment for the patient's care."

• Find the best solution to barriers: Financial issues tend to be one of the types of barriers that sometimes require creative solutions. (*See story about solutions to discharge barriers, p. 70.*)

"One of the big things we've done is form two

special accounts that we fund to help patients who are staying in the hospital because of medication needs and their lack of funding or insurance," Morris explains. "So, if the patient needs IV medications, we help the patient get this in the community, so we can free that bed."

The hospital team might work with different companies to get the medication donated or have the risk shared. Sometimes the patient can pay a little, and the hospital will pay for the rest out of the special fund, she adds.

In another example, patients sometimes need a new medication that is very expensive and poses a barrier to discharge. In this case, the hospital pharmacist would review the drug to make certain it is the optimal medication for treating the patient and to see if there are any alternative drugs that would work as well.

SOURCE

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If discharge barriers arise, consider these solutions

Solutions range from commonsense to creative

A hospital's discharge process could be well-organized and include best practices. But what happens when patients are kept in an acute care bed, because the usual care transition options will not work?

A Stony Brook, NY, hospital has encountered this issue multiple times and has developed a variety of practices to resolve the problem. Here are some of the discharge solutions:

• **Discharging patients who are undocumented immigrants.** This is a problem that occurred often enough that the hospital's discharge team included it in the discharge barrier coding system.

"We developed a budget for patients to provide after care until they can get on their feet or until someone else can assist them," says **Catherine Morris**, RN, MS, CCM, CMAC, executive director of care management at Stony Brook (NY) University Medical Center.

The budget might pay to send the patient to a sub-acute facility in the patient's home country or to fly the patient's parent or other caregiver

CNE questions

9. A patient-friendly discharge education sheet might include which of the following?
A. It lists patient's admission date, discharge date, and days in the hospital.
B. Under the section of "Diagnosis," there are notes written after these three statements: "I had to stay in the hospital because," "The medical word for this condition is," and "I also have these medical conditions."
C. The treatment section states, "While I was in the hospital I was treated with ____"; "The purpose of this treatment was: ____"
D. All of the above

10. A new study is looking at the use of a wireless monitoring device that can be left in patients' homes post-discharge. The goal is to reduce readmission to the hospital. How is the device helpful?
A. The device gives patients oral instructions and reminders about taking their medications.
B. The device sends data from a special weight scale and a blood pressure monitoring device and issues warnings sent to a central call center when patients have readings that suggest a problem.
C. The device serves as a wireless communication tool in which patients can beep their health care provider.
D. All of the above

11. According to a medical school professor who also had an alarming experience as a heart patient, what is one of the key things hospital discharge planners can do to ensure a better care transition for patients?
A. Spend at least 45 minutes with each patient prior to discharge.
B. Give patients educational material that is translated into their native language.
C. Learn what it is that patients need and want at the time of discharge and then implement changes that address those needs.
D. None of the above

12. A hospital implemented a discharge coding system to identify discharge barriers and found that which of the following was an important barrier to patients being discharged successfully from the hospital?
A. Community resource issues
B. Patient or family issues
C. Financial or insurance issues
D. All of the above

Answers: 9. D; 10. B; 11. C; 12. D

to Stony Brook, so the caregiver could assist the patient when discharged to the community.

"Some of these patients might have a payer source for while they're in the hospital, but no funds for care once they're discharged," Morris notes.

The hospital's social worker will help locate the patient's family members and assist with contacting them.

"We've tried to do some creative things," she says.

For instance, the hospital has been exploring the possibility of having an affiliation with local subacute facilities to rent or purchase beds for patients who need to be discharged to a lower level of care, but have funding problems, she says.

• **Handling transitions when guardian issues arise.** Another obstacle to a smooth care transition can be guardianship when patients are unable to make their own care decisions.

In New York, the attorney general's office makes decisions about guardianship of adults, and this can be a lengthy legal process, Morris notes.

Patients were holding up hospital beds, solely because the guardianship paperwork was held up in overcrowded court dockets.

"We've been working with the attorney general to move the guardianship papers forward," Morris says.

They found that one solution to the lengthy guardianship court process was to request a temporary guardian, who could participate in the patient's discharge planning and Medicaid application process.

"Now, we don't have to wait until the full guardian is appointed, which could take several months," she adds. "The patients would be in the hospital that whole time."

• **Finding solutions to dialysis patient issues.** The hospital's discharge coding system identified a barrier resulting from the lack of dialysis beds in the region. This problem means patients stay in the hospital longer than optimal, she says.

"The hospital is putting together a proposal to talk with the dialysis center to rent or purchase dialysis chairs," Morris says. "Depending on the final proposal, we'll either subsidize the treatment until the patient's insurance kicks in, or we'll look at doing a risk agreement with the dialysis center."

• **Dealing with increases in uninsured patients.** The economic downturn has increased the number of unemployed in the hospital's region, and the hospital has had increases in patients who arrive without insurance coverage, Morris notes.

"We have nowhere to place these patients, because other facilities won't take them," she explains. "And the Medicaid application process takes 45 day for approval, so we sometimes have to wait 45 days before discharging them."

Sometimes these patients could be discharged to a facility that would provide charity care, and sometimes the hospital discharge team could

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

CNE objectives

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.

help them obtain home care services. Also, some patients qualified for the hospital's indigent funding. But as the problem grew, a bigger solution was needed, Morris says.

"We put together a medication assistance fund for patients who are uninsured or underinsured and who need only IV medications," she says. "We can work out something with the patient where the patient pays a part and we pay a part to provide them with the medications at home, so we can free up the bed and reduce our costs."

Another solution was for the hospital to work with the state department of social services to make sure Medicaid applications are going through in a timely manner, Morris says.

One solution was having a state Medicaid representative stationed in the hospital to help with Medicaid applications, she adds.

This has helped to speed up the application approval process, an outcome the discharge coding barrier system can track.

"There were many delays with Medicaid approvals," she says. "We keep track of any Medicaid application delays so we can give a report back about how their new program is affecting us."

The hospital hasn't rented beds yet, because the legal office still is exploring legal and regulatory issues, she adds.

Also, some patients who are waiting for Medicaid cannot afford their copayments when they are discharged to a lower level of care, so the hospital will share the cost with them, Morris says.

• **Resolve care management issues.** "Sometimes there's a care management delay, where the care managers didn't act as quickly as they could have," Morris says. "The physician or care team might be treating a patient whose case is medically futile, but the family demands aggressive treatment."

The patient might be in the intensive care unit (ICU), and indecision has kept the patient there for longer than necessary. If the physician refuses to stop the futile treatment, an ethical consultation will be called.

"We also work closely with our palliative care group and refer patients to them," Morris says.

There are other care management issues, as well.

"It might not be clear what the physician has in mind for the discharge plan, or maybe the discharge plan is not compatible or realistic, based on what services are available," Morris says. "If they say, 'I want the patient to go to sub-acute rehab,' but the patient doesn't meet the criteria for rehabilitation, then that's cause for delay."

The hospital's full-time physician advisor is involved with patient meetings where these care management issues are discussed.

"The physician advisor will review what is doable and what is not doable, and she'll go to the chief medical officer, if necessary," Morris says.

Also, the physician advisor will speak with the attending physician to make sure everyone is doing what's best for the patient and is being realistic about what can be done for the patient, she adds. ■

DISCHARGE PLANNING
ADVISOR

DPA120110TM

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 credit letter.

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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 credit letter.**

CORRECT ● **INCORRECT** ✓ ✗ ⦿ ⊘

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

After participating in this program, I am able to:	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
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.

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

DISCHARGE PLANNING ADVISOR

2010 Index

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