DISCHARGE PLANNING
A D V I

Note: New CNE/CME procedures. See p. 47 for details.

July/August 2011: Vol. 4, No. 4
Pages 37-48

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Financial Disclosure:
Editor Melinda 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.

AHC Media

Special Report: Improving care transition communication

Communication during care transitions should be training priority in hospitals

Variety of models exist for improving communication

[Editor's note: In this issue of Discharge Planning Advisor, *there is a special report about how health care systems and discharge teams can improve communication between providers and patients/families. Federal agencies hold hospitals responsible for poor care transition outcomes, and often the chief culprit is a breakdown in communication. Various articles in this issue will focus on the existing communication issues and what hospital care transition teams can do to prevent or improve these areas.]*

Health care systems have a few years to improve care transition communication and processes before health care reform changes make concise and clear communication essential, experts say.

The Centers for Medicare & Medicaid Services (CMS) will hold providers responsible for medical errors that result from poor transitions. Improved communication and provider-to-provider instructions at hospital discharge will be crucial to preventing these mistakes.

"I think there's a recognition that failure to communicate about patients at points of transfer, whether between care providers or settings, could result in serious harm to patients," says **Ann S. O'Malley**, MD, MPH, a senior researcher at the Center for Studying Health System Change in Washington, DC.

"It's an issue of coming up with systematic processes to make sure the person taking care of the patient communicates to the person to whom the patient is going," O'Malley says.

"With the development of new health information technologies and the efforts to get them to communicate with one another, we have the opportunity to use these tools to enhance the exchange of data and important clinical information about patients," she adds.

EXECUTIVE SUMMARY

- Federal officials will hold providers responsible when poor transitions result in medical errors.
- New health information technology offers opportunity for improved care transition communication.
- Family dynamics affect hospital discharge team's communication with patients.

For example, hospitals could use electronic data sets or checklists to assist with the care transition process and hand-offs.

"Like pilots have a checklist before they take off, hospitals need checklists to bring efficiency into the health care system," says **Diane Feeney Mahoney**, PhD, ARNP, BC, FGSA, FAAN, a Jacques Mohr professor of geriatric nursing research at the MGH Institute of Health Professions in Boston.

Mahoney and co-investigators studied the use of a minimum data set to improve communication between emergency departments and nursing homes. Their study found that a transitional minimum data set could result in an improved transfer of essential clinical information, but there needs to be greater consistency of usage.[1]

The key is to create standardized questions that will work for a particular health care setting. Also, these should be honed to the most critical elements, Mahoney says. *(See story on the TMDS study, page 40.)*

"You don't want information overload," she adds. "If you send 20 pages of information, and a critical item is on the 18th page, it might be overlooked."

The chief drawback to improved communication between providers is that there's no payment for coordinating care, O'Malley says.

"There are few financial incentives for having a thorough discussion of patient information at the point of transfer," she explains. "We have disincentives for effective communication built into our current payment system because communication is not a reimbursable task."

Every time a clinician takes time to communicate with a provider, that's time not being spent on reimbursable activities, she adds.

The other issues are that support systems need to be put in place to improve care transition, and clinicians still are not trained to think outside of their silos of care, O'Malley says.

"We think about what happens in the hospital, but not what happens when patients leave the hospital," she says. "So we need some kind of increased emphasis in our training as nurses and physicians on the fact that patient care includes everything we've done and what happens when the patient leaves the hospital."

One strategy for improving care transition communication is to have a point person to work with the hospital and community providers to improve care transition communication and follow-up. This person could be a designated hospital discharge planner, case manager, nurse practitioner, or some other discipline.

The Mount Sinai Visiting Doctors Program of New York developed a nurse practitioner-led model as part of a pilot transitional care program, says **Theresa Soriano**, MD, MPH, director of the Mount Sinai Visiting Doctors Program and director of the Mount Sinai Chelsea-Village House Call Program.

"We started the program because of a realization that as our primary care program was getting bigger, there was a need of communication between our program's physicians and nurse practitioners and inpatient hospitals," Soriano says. "We hoped

Discharge Planning Advisor (ISSN# 1940-8706) is published every other month by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, NE, 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 105109, Atlanta, GA 30348.

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 activity is valid 36 months from the date of publication.

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

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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.)

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this would streamline the flow of patients as they came into the hospital and communicate their medical conditions and reasons for being admitted."

The purpose of the Mount Sinai Visiting Doctors Program is to make care transitions as smooth as possible and improve the flow of information, says **Maria Tereza Lopez-Cantor**, MA, ANP-BC, CCRN, a nurse practitioner with Internal Medicine Associates — PACT at Mount Sinai Medical Center. Lopez-Cantor and Soriano were among the authors of a study on the program.

Their research showed that this model is feasible for enhancing inpatient management and transitional care for a population of patients at high risk of readmission.[1]

This type of model can be a way to address high 30-day readmission rates for the same medical problem. This issue is targeted by CMS, which will penalize hospitals that fail to improve.

"The three big issues that CMS is looking at are heart failure, pneumonia, and acute myocardial infarction," Lopez-Cantor says. "We don't limit our work to those medical issues."

Hospital transition care staff need to concentrate on communication between the hospital team and community providers, but there also are deficits that should be addressed in how the discharge plan is communicated to patients' informal caregivers.

Informal caregivers are not always aware of the discharge process details and would like more information, says **Janice B. Foust**, PhD, RN, an assistant professor in the College of Nursing and Health Science at the University of Massachusetts Boston and a nurse research associate at the Visiting Nurse Service in New York.

"As we look at where we need to move to improve transitions from hospital to the home care setting, there could be proactive involvement of informal caregivers or family caregivers during hospitalization and at discharge," Foust says.

Another finding in Foust's study was that patients do not recall much detail about discharge instructions, which suggests different teaching methods need to be employed, she adds. *(See story about study on patient and caregiver perspectives at discharge, page 42.)*

Written discharge instructions are an important way to communicate the care transition process to patients and their caregivers. But they're also a way to communicate with community clinicians about what took place in the hospital, Foust notes.

"It is important to recognize that they are very versatile as a way to communicate to patients, family caregivers, and clinicians alike," she adds.

Communication between hospital clinicians and patients' family members or caregivers can be turbulent at times, says **Lori L. Popejoy**, PhD, APRN, GNS-BC, John A. Harford Foundation Fellow and assistant professor in the Sinclair School of Nursing at the University of Missouri in Columbia.

Popejoy interviewed patients, their family members, and health care team members to learn how their perceptions of the discharge process were alike and how they were different.

"I wanted to find out how they achieved congruence between these three different groups," Popejoy says. "How did they arrive at an agreement about where the patient was going to leave when he left the hospital?"

The findings surprised her.

"Older adults don't tell their children everything," Popejoy says. "They tell them what they want them to know and what they think they should know."

This can be problematic when the older spouse of a patient is unable to handle the patient's care at home, but he or she is reluctant to let other family members help change a discharge plan for a safer transition.

Popejoy's study of the family and clinician dynamics at hospital discharge has implications for how hospitals might improve communication during this process. *(See story on family dynamics and risk at discharge, page 43.)*

For instance, hospital discharge staff should know many of their patients' interpersonal dynamics because often the people they see have been in the hospital previously, and they should communicate this information to community providers, such as home health agencies, Popejoy suggests.

"Communicate the patient's degree of risk at home," she says. "This risk is why patients are readmitted, and we should stop the cycle."

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Special Report:
Improving care transition communication

Hospitals could use TMDS to convey data

Study shows improvement with its use

One important obstacle to clear, effective care transition communication is the format in which information is conveyed. If information about hospital patients is sent electronically, what should be included? Which fields are essential? And is it possible to include flexibility in an electronic form or data set?

Researchers at the MGH Institute of Health Professions in Boston have developed a transitional minimum data set (TMDS) that might serve as a model that addresses and resolves these issues. The TMDS tool was developed based on a literature review and an expert panel's suggestions. A study of the TMDS in use found that it was associated with marked improvement in the transfer of essential clinical information, although additional educational efforts were needed to improve consistency in its use.[1]

"Our focus was to help avoid hospital admissions for elders who go to the emergency room from long-term care facilities," says **Diane Feeney Mahoney**, PhD, ARNP, BC, FGSA, FAAN, a Jacques Mohr professor of geriatric nursing research at the MGH Institute of Health Professions.

Mahoney and co-authors sought to make the encounter in the emergency department more productive.

"Many elders who come to the emergency department are confused," Mahoney says. "So you need to know how they were normally; were they alert or confused? How did they normally function? Also, what are their risks for falls, aspirations, wandering, and seizures?"

The TMDS collects these details, giving clinicians a broader picture of who the patient is and what a particular patient's "normal" should look like.

"The emergency department staff loved it," Mahoney notes. "They felt the data set helped save them time, and they could more quickly focus on the issue at hand."

The form's usage rate was 91%, indicating it was widely adopted in clinical practice.[1]

Such a data set also can include information about the nursing home or other provider to which the patient will be transferred. For instance, the data set could show hospital discharge providers that a particular nursing home does not provide access to acute rehabilitation, which the patient will need, Mahoney says.

"This checklist appears to work, and it improved communication in the study, despite the fact that it was new and a pilot effort," she says.

One area that did not improve with the use of the data set was the reporting of the patient's tetanus/diphtheria vaccination status, Mahoney notes.

"We were surprised this part didn't improve, and it was the only thing that didn't," she says. "The emergency department staff really wanted to know someone's tetanus/diphtheria status, and that was on the form as a critical area, but only 3% had sent that information before and only 5% sent it with the TMDS form."

This is a communication deficit that nursing homes should address since it's critical to hospitals, and emergency medicine clinicians do not have time to search through hundreds of pages of documentation to find the answer, Mahoney adds.

A potential solution would be a better graphic

EXECUTIVE SUMMARY

- A 30-item data set was designed to improve transitional care information transfer across settings.
- The data set can include pre-populated demographic and contact information.
- Embedding data set in electronic medical record could make transition communication more seamless.

design of the TMDS, making it easier for nursing home staff to see the question and provide an answer, she suggests.

An electronic transitional minimum data set also could be pre-populated with basic information, making it easier and faster to complete. For instance, the names and numbers of key staff, such as social workers and medical directors, could be pre-populated in the form.

"This is so people don't have to fill out everything under a crisis," Mahoney says.

Another way the TMDS could be improved is if the data set were embedded in an electronic medical record (EMR) as part of a standard form used at times of care transition. The EMR would not let users proceed until they answer all of the essential questions, she says.

With a data set embedded in an EMR, the pre-populated information could include the patient's basic demographics and family contacts.

"If they do not know the patient's tetanus vaccination status, then they can put in the form that it's unknown," Mahoney explains.

While MGH Institute's data set form was used solely from the nursing home to the emergency department, it easily could be created for hospitals to use and send to community providers, she says.

"I would think nursing homes would want to know how the medications were changed and what were any new diagnoses or new syndromes or exacerbation of syndromes," Mahoney says. "They'd need to know more about how to manage the patient's symptoms, and they could learn which information from the hospital could help the nursing home prevent readmissions."

Hospitals using such a data set could seek input and buy-in from the community providers who will be using it.

"They could educate nursing homes as to the utility of the form," Mahoney suggests.

The TMDS study followed hospital admissions from a 140-bed nursing home. There were 33 cases in the baseline comparison group and 41 cases in the post-TMDS group, she says.

The skilled nursing facility averaged 17 emergency department transfers per month. Investigators determined the effectiveness of the TMDS tool by measuring the proportion of TMDS items received by the emergency department after implementation of the TMDS when compared with prior care.[1]

The TMDS tool had 30 items, but its length did not appear to be a barrier to its adoption by clinicians, Mahoney says.

Users of the tool suggested that it list why the patient was being transferred, providing space for more detail or an open-ended question, she says.

Hospitals and other health care providers increasingly will find they need to use tools and checklists to improve communication during care transition, Mahoney says.

"The regulatory side wants it; the technology side can do it, and now there are more financial incentives for facilities to adopt the technology that makes it possible," she explains. "Everybody knows issues get dropped."

So it's important to determine the critical elements that will make the transition safe and successful, and these elements need to be collected quickly and efficiently, she adds.

The purpose in having a TMDS tool is that it asks the right questions for the provider receiving the patient. This provides a greater understanding of the situation since each provider has different priorities and the nursing home might need to know different information than do emergency department physicians.

"The patient's status is a moving target, and it's critically important that we keep that information about him easily achievable," Mahoney says.

For instance, a nursing home patient's data set might indicate he was walking to dinner, sitting with friends, and having conversations a couple of months earlier. So the dementia noted when he was brought into the hospital might be delirium caused by a recent infection or new medications, and it's been misidentified as Alzheimer's disease, she explains.

With the correct information readily available to hospital clinicians, the patient's care plan and goals are adjusted with the hope of returning the patient to his former level of function.

"We want to get patients back to their pre-existing best optional functional level," Mahoney says.

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Study shows issues with discharge instructions

Written instructions can be illegible, unclear

Patients and their caregivers sometimes have difficulty recalling details of their discharge instructions, a new study finds.[1]

Family caregivers recalled hearing very little information about the patient's hospital discharge, the study finds.

"I think that was frustrating to them at times," says **Janice B. Foust**, PhD, RN, an assistant professor in the College of Nursing and Health Science at the University of Massachusetts Boston and a nurse research associate at the Visiting Nurse Service in New York.

Communicating with informal caregivers is difficult from the hospital staff's perspective because there often are multiple people involved, Foust notes.

There are practical implications, such as trying to determine who the true caregiver is. Sometimes discharge staff will give instructions to the person visiting the patient at that moment, but this might not be the caregiver who will be helping the patient carry out the discharge plan.

"Find out who will work closely with the patient at discharge," Foust says.

"It's an important step to ask patients who else they would like to be involved in discharge planning and who else should know about this information," she says. "There needs to be collaboration with patients because it's their health, and they should give permission as to who should receive these discharge instructions."

Foust's research has found that home health agencies also report significant issues with how hospital discharge instructions are handled. Home health clinicians commented on problems with illegible instructions, incomplete instructions, and missing instructions.[1]

"The earlier the home care agency is involved in the care, the better," Foust says. "If they are involved while the patient still is hospitalized then it likely is of benefit and will make for a smoother transition."

Home health clinicians are a valuable resource and support for patients, and they should be more proactively included in the hospital discharge process, she says.

EXECUTIVE SUMMARY

- What patients and caregivers hear is different from what providers communicate.
- Involve home care agencies earlier in discharge process to improve process.
- Give patients a more detailed action plan at discharge.

Conversations between the hospital's discharge team and the home health team can be enormously beneficial to patients and improve the care transition, Foust adds.

"Home health clinicians observed that sometimes discharge instructions get set aside once a patient is at home," Foust says. "Hospitals could make the instructions easier to stand out, maybe with a bright color."

Also, hospitals could follow-up the written instructions with podcasts or other educational support for patients and caregivers.

When there are written instructions, it's important the writing is legible so the home health clinician can easily read and understand them, Foust suggests.

"Home health clinicians sometimes noted that families could use more support and preparation," she adds.

It also would be helpful if hospitals provided patients with a more detailed action plan at discharge, Foust says.

"This would help home health clinicians know who to contact when there's a finding, an early sign or symptom," she adds. "Home health agencies have policies in place about how to contact the hospital, but the hospital discharge instructions could reinforce what is of concern and how and when to contact them."

These strategies might help to prevent hospital readmissions, and they reinforce the collaboration between the home care agency and the hospital.

"I think the home health agency can be a tremendously important part of somebody's post-hospital transition," Foust says. "When we speak specifically to transitions from hospitals and as people are recovering, home health is a valuable resource and can provide support for people who need to recover at home."

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Special Report:
Improving care transition communication

Transition team deals with risky situations

These scenarios often arise

The hospital discharge process for patients most at risk for readmission would be much simpler if discharge nurses or managers were able to simply explain what a patient needs to do next and know that the patient and family are ready to follow those instructions.

In reality, it rarely works that well.

Hospital discharge planners typically have to navigate situations in which the best care transition plan for a particular patient is the one that the patient or the patient's family members are not interested in pursuing. Or, discharge planners might think a family is on board with a particular strategy, but they learn otherwise when the patient bounces back to the emergency room a few weeks later.

These tricky situations are why the hospital transitional care team needs to learn how to communicate with families and patients when the family dynamics are particularly challenging.

"This kind of work is extraordinarily complicated when you think about the large number of players and stakeholders involved in any decision," says **Lori L. Popejoy**, PhD, APRN, GNS-BC, John A. Harford Foundation Fellow and assistant professor in the Sinclair School of Nursing at the University of Missouri in Columbia. Popejoy recently published a study about the complexity of family caregiving and discharge planning.[1]

Popejoy outlines these types of hospital team-patient/family interactions and how communication problems can be avoided:

• **Scenario: Patient withholds information from some family members.** Often, a hospital discharge team will find that the patient and his or her spouse do not want to disclose all of their health information to their adult children, Popejoy notes.

"They live their lives the way they want, and they don't want any interference in their lives," she explains. "Their kids are still their children, and their kids aren't running the show."

The patient's wishes would be honored by the health care team, but the situation becomes problematic when it becomes clear the patient and spouse will need some kind of community/family support. So the hospital team should be very clear in their communication with the patient regarding what kind of additional help he or she might need and whether this help will require assistance from family, friends, neighbors, or other informal caregivers.

"The health care team is respectful of where family members fall on this continuum of what the patient is willing to tell them," Popejoy says.

But patients will change their minds, and some patients might have cognitive decline, suggesting that they are not competent to make their own health care decisions and input from family members is necessary.

"You have to make a judgment call about who is competent and who is not," Popejoy says.

• **Scenario: Older patient's spouse is too frail to handle the patient's physical care at home.** When a patient is admitted to the hospital from home where he or she lives with a spouse, then the couple typically expects to return home at discharge, Popejoy says.

The discharge team might believe a nursing home is a viable option for rehabilitation, but if the couple resists this option, then the situation becomes complicated.

"If they were living with their spouse then they might want to go home with their spouse, and the spouse could be willing to do whatever it takes to bring that person home," she explains. "But as a healthcare provider, you want to make the best choice for the family."

There often are cases where the spouse is at risk physically, particularly when a small and frail wife is taking home a large, elderly husband who has functional deficits, she says.

"He can't walk very well; he can't bathe himself, and there's a danger of the female being hurt inadvertently when caring for him," Popejoy says.

"You'll need to put in a strong personal care plan for that situation," she adds.

The health care team also should communicate clearly the financial responsibilities in implementing this care plan.

• **Scenario: Patient's discharge expectations**

EXECUTIVE SUMMARY

• Family dynamics play tricky role in discharge process.
• Communicating with families and patients takes practice, skill.
• Explain clearly why patients need a brief nursing home stay before returning home.

clearly are unrealistic. Patients sometimes strongly disagree with the hospital team about Plan A at discharge. For instance, the patient needs complex intravenous therapy, and the discharge team has determined that the patient's family will be unable to provide this care adequately. Yet the patient insists on returning home.

"We have this idea of autonomy and if someone says they should be able to do it, they should be able to do it, but the truth is that people say they can when they can't," Popejoy says. "Then they're turned around and hospitalized because they can't handle it."

The solution here is to speak candidly with the patient and family about what will happen when the patient is discharged.

"We can say, 'This is what it takes to get you up in the morning; right now you're so weak you can't move to your wheelchair, so how will we get you from the bed to the wheelchair when you're home?'" Popejoy suggests.

The discharge planner can explain how the patient will need to be discharged from the hospital before he or she is back to a prior level of functioning, but there is a plan in which the patient could go to a skilled nursing facility for short-term rehabilitation before heading home.

"Then you can tell them, 'When you come home, here are the services that will be reinstated,'" Popejoy says.

Clearly explain that Plan A is to discharge the patient from the hospital to the next level of care and from there to their ultimate goal of returning home. The skilled nursing facility is a bridge to get the patient to that goal, she adds.

"You need to be very clear on what the patient's deficits are and be clear with them about the complexity of the problem," she says. "Usually there's a functional deficit in their ability to care for themselves."

Draw a concise picture of where the patient's current functional status is and what is required for the patient to become independent, Popejoy suggests.

"You can say, 'We don't know if you'll be able to do that, so you need to get stronger and not hurt yourself,'" she says. "Then be clear that the ultimate goal is to go home, and that ultimate goal needs to be articulated to the rehab facility if that's the goal."

Also, the hospital team should reassure the patient that the nursing home stay is temporary because they fear they'll be admitted and then never leave, she says.

• **Scenario: Patient wants to return home, but adult child is uncomfortable with plan.** This scenario is a twist on the theme of patients wanting to return to their own homes and independence.

In this case, a hospital nurse might be pulled aside by the patient's daughter or son, who says, "Can you talk some sense into my mother? She needs to go to a nursing home and stay there, but she wants to come home. It makes me uncomfortable," Popejoy says.

Incorporating these family member's concerns into the discharge plan is tricky because the patient might have expectations that the child will become a caregiver, while the child clearly does not want this role. The best strategy might be to help the patient realize what he or she will need to stay healthy and happy, she says.

Sometimes patients will reject the discharge team's first-choice option of having the patient transitioned to a skilled nursing facility, and the less desirable Plan B will take place.

"In my study, social workers and nurses talk about acknowledging that they sometimes send patients home with the best plan they can, but they knew it would fail," Popejoy says.

If the patient rejects Plan A in which he or she would be transitioned to a skilled nursing facility, then what's left is Plan B in which the patient is sent home with as many support services as can be found. In accepting this less than desirable option, the hospital team should be aware that the patient likely will be returning to the hospital. And when this happens, it might be time to again stress the importance of a nursing facility plan.

"We need a plan that will enable them to be successful wherever they are going, and we need a back-up plan on call," Popejoy says. "If you send the patient home, that might be not the best choice, so what is Plan B going to be?"

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Identifying sources of support for families

Families increasingly are bottom line

One of the chief issues as hospitals continue the trend of transitioning more patient care to subacute or community/home settings is the availability of financial and service resources.

In some areas, including rural regions, this can make discharge planning much more complex.

"The challenge is that we have had a slow eradication of personal care in this country," says **Lori L. Popejoy**, PhD, APRN, GNS-BC, John A. Harford Foundation Fellow and assistant professor in the Sinclair School of Nursing at the University of Missouri in Columbia.

"You can pay for it privately, or your family can do it for you, or you might be Medicaid eligible and receive some personal care services," Popejoy says.

But Medicare provides far less personal care support than it once did.

"Medicare visits are shorter with home care and not as generous as they used to be," Popejoy says. "So who picks up the slack? It's the family and it's the spouse."

This is why the discharge team should identify other sources of support for the family when an elderly patient desires to return home and this poses a health risk. The hospital team can do this by making repeated visits to the patient while the patient is hospitalized and learning the family situation. If the family is amenable to home care visits and these visits can be financed, then the discharge team should communicate the family's history to the home care agency, so they'll also be aware of the risk, she adds.

"Ten years ago we'd have home- and community-based services for people who are nursing home- or Medicaid-eligible and these services would keep them out of the nursing home," Popejoy says. "The services would include personal care shopping, yard care, and transportation to doctor's appointments."

Now such concierge services are not available except to those with the best health care or financial resources.

"The barriers to keeping people out of the hospital are pretty extraordinary for some cases," Popejoy says.

So hospital discharge teams need to assess a patient's personal resources, including family members or neighbors who would be willing to take him or her to follow-up doctor visits and take care of other household chores.

When it's clear these community-based resources are inadequate, the team should discuss the issue with patients and their family members, asking if there are any additional personal resources the patient might have.

In some cases the resources are less than ideal, but if the patient desires them, this should be the goal. For instance, the patient might be living with an unemployed child who is financially dependent on the parent, but does provide some support for household tasks and personal care.

"Yes, they're living off mom's Social Security check, but they're taking care of her, and she is well cared for and clean," Popejoy says. "People might find themselves in that situation unexpectedly."

These situations will become more common as increasing numbers of Americans pass age 60 and their health declines. Plus the trend of dwindling community and national support services will continue, Popejoy predicts.

"We're faced with pretty huge challenges in the next decade," she says.

"The population is getting old pretty fast, and they'll use more hospital days," she adds. "All of this is happening in the face of a declining health care workforce."

Patients who lack community resources are discharged home. Soon they are readmitted to the hospital, a cycle that continues when there are no interventions to find alternative transitional care options.

"I see it as a perfect storm on the horizon," Popejoy says. "We have an increasing population of older adults; some live with their children; some are on their own; some live with spouses."

It's the hospital discharge team's job to help their transition be one that is not just physically moving them from the hospital to a new place, but also one that helps patients continue to improve their health and mobility.

Family dynamics should be a chief focus of transitional care teams as the nation's health care focus increasingly places more responsibilities on the family, Popejoy notes.

"Ninety-five percent of people live in the community, and for the most part we handle this successfully," she says.

"Also, most of the personal care and post-hospital health care is delivered by family members, so the patient's family is the backbone of our system," she adds. "From a discharge planner's perspective, the family is your strength, and they're the ones who will keep things going." ■

EXECUTIVE SUMMARY

- More people will need personal care services at home, but fewer will receive these, experts say.
- Medicaid and Medicare pay for less home-based services than they did previously.
- Patients increasingly will need to rely on family caregivers when they return home.

Latest SREs include a care transition issue

Strategies can be found in "Safe Practices"

The Washington, DC-based National Quality Forum (NQF) Board has updated its list of serious reportable events (SREs) in health care, adding one that directly affects how hospitals handle care transition communication.

Specifically, NQF has added a new SRE that states, "Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results."

The SREs, which were first published in 2002, are updated and refined based on the evolution of the evidence, as well as in reaction to adverse events and recommendations from organizations and individuals, says **Melinda L. Murphy**, RN, MS, senior director, NQF performance measures department.

The SRE related to failure to follow up or communicate lab, pathology, or radiology test results began as a recommendation regarding failure to follow-up or communicate clinical information, Murphy notes.

"People gave us feedback on the initial draft report where we had the more broad statement related to clinical information," she explains. "And at that point during the comment period we received feedback that suggested we could make a more refined, clear, and specific statement."

The NQF's SREs number 29 in all. These cover a range of health care areas, representing preventable errors and events, including pressure ulcers, patient falls, and serious medication errors. These are used by states and organizations in reporting systems and best practice standards.

"Well over half the states now report adverse events that occur to patients, and many of those states use the NQF-endorsed series of SREs for their reporting," Murphy says.

Here's a hypothetical example of a serious reportable event that might match the new standard during a care transition moment: A patient is in the hospital to have a series of tests related to a particular condition and symptoms. Then the patient is discharged before all of the test results are available, Murphy says.

"Somewhere along the line, those tests go missing in transmission from the hospital to my doctor's office or in a letter that was supposed to go to the patient," she adds.

The missing report says the patient has a treatable cancer. But because the patient and the patient's physician never receive the report, the patient's cancer worsens, and the patient dies, Murphy says.

In another hypothetical example, a newborn is discharged from the hospital with an elevated bilirubin level not communicated and followed up. This results in kernicterus, which can lead to serious neurological complications, such as brain damage.

CNE QUESTIONS

1. The Centers for Medicare & Medicaid Services (CMS) initially has targeted for improvement 30-day hospital readmissions in which three areas?
   A. Chronic obstructive pulmonary disease, bronchitis, urinary tract infections
   B. COPD, pneumonia, GERD
   C. Heart failure, pneumonia, acute myocardial infarction
   D. Heart failure, leg ulcers, urinary tract infections

2. A new study shows that a transitional minimum data set sent to providers during care transition could achieve which benefit?
   A. Satisfaction among clinicians receiving the information
   B. Improving communication between community and hospital providers
   C. Improve the collection of tetanus/diphtheria vaccination status
   D. Both A and B

3. True or False: Personal care services that Medicaid-eligible patients at risk for hospital readmission once received are rarely available now outside of private pay.
   A. True
   B. False

4. The Washington, DC-based National Quality Forum (NQF) Board has updated its list of serious reportable events (SREs) in health care, adding which of the following:
   A. Patient death resulting from a failure to follow-up on patient's health status at home, nursing home, or other community setting
   B. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
   C. Patient injury resulting from hospital transitioning patient before recovery was complete
   D. All of the above

"As a consumer in this country I would like those kinds of events to be reported for the learning and prevention strategies that can occur," she says.

"From the very beginning, that has been the intention of the SREs — to find a way to capture events, know what types are occurring, how frequently they are occurring, to identify the most frequent and harmful events in order to identify solutions across organizations and states," she explains.

The National Quality Forum already has a list of safe practices that addresses communication and hand-offs across providers and organizations, Murphy notes.

"The intent is to improve communication about what goes on with a patient from one provider to another to ensure continuity," she explains. "Underlying all of this is prevention of these events, which cause serious injury and sometimes death."

The NQF's latest list of safe practices, published as the "Safe Practices for Better Healthcare – 2010 Update," includes some guidance on how to prevent problems involving care transition and discharge communication. Its care transition safe practice guidance includes the following:

• **Safe Practice 12:** Patient Care Information — Ensure that care information is transmitted and appropriately documented in a timely manner and in a clearly understandable form to patients and to all of the patient's healthcare providers/professionals, within and between care settings, who need that information to provide continued care.

• **Safe Practice 13:** Order Read-Back and Abbreviations — Incorporate within your organization a safe, effective communication strategy, structures, and systems to include the following:

— For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person who is receiving the information record and "read-back" the complete order or test result.

— Standardize a list of "Do Not Use" abbreviations, acronyms, symbols, and dose designations that cannot be used throughout the organization.

• **Safe Practice 15**: Discharge Systems — A "discharge plan" must be prepared for each patient at the time of hospital discharge, and a concise discharge summary must be prepared for and relayed to the clinical caregiver accepting responsibility for post discharge care in a timely manner. Organizations must ensure that there is confirmation of receipt of the discharge information by the independent licensed practitioner who will assume the responsibility for care after discharge.

• **Safe Practice 17:** Medication Reconciliation — The healthcare organization must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care.

EXECUTIVE SUMMARY

- The National Quality Forum added a new serious reportable event related to care transition.
- The new SRE discusses patient safety when lab results are not communicated during care transitions.
- NQF advises hospitals to ensure that care information is transmitted in a timely, understandable way.

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.

CNE instructions

To earn credit for this activity, please follow these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

COMING IN FUTURE MONTHS

■ Experts suggest plan for finding best sub-acute care providers

■ Collaborations with home care liaisons can improve care transition

■ Hospital's consistent care program saves millions, reduces ED visits

■ Discharges after brain injury pose unique challenges

SOURCES

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Care transition news

HHS to award $500M to improve care

Funds are through Affordable Care Act

The U.S. Department of Health and Human Services (HHS) announced in late June 2011, that it would provide $500 million in Partnership for Patients funding to help hospitals, health care provider organizations, and others improve their efforts to prevent injuries and complications related to health care acquired conditions and unnecessary readmissions.

The funding comes from the Affordable Care Act of 2010, and it will be awarded by the Centers for Medicare & Medicaid Services (CMS) Innovation Center.

The CMS Innovation Center will seek contracts with local and statewide entities that can support hospitals' efforts to improve health care and reduce risk for patients.

The Partnership for Patients is a new public-private partnership that was created to improve quality, safety, and affordability of health care for all Americans. Its chief goals are as follows:

• Reduce harm in hospital settings by 40%;

• Reduce hospital readmissions by 20% over a three-year period.

Health care systems, associations, state organizations, and other groups will work with the Partnership for Patients to redesign care processes in an effort to achieve these goals.

Designated hospital engagement contractors will be asked to conduct the following:

• Design intensive programs to teach and support hospitals in making care safer.

• Conduct training for hospitals and care providers.

• Provide technical assistance for hospitals and care providers.

• Establish and implement a system to track and monitor hospital progress in meeting quality improvement goals.

CMS will work with hospital engagement contractors and other contractors to develop ideas and practices that will improve patient safety in various areas, such improving patient safety and transitions between health care settings. An example would be when a patient is transferred from the hospital to a skilled nursing facility.

These contracts will amount to $500 million, and solicitations for proposals are available on the Federal Business Opportunities website at www.fbo.gov.

When President Obama first announced committing $1 billion in Affordable Care Act funding to achieve the patient safety goals, $500 million was made available through the Community-based Care Transitions Program to ensure patients safely transition between settings of care. The $500 million in Partnership for Patients funding is additional money to help reduce health care acquired conditions and reduce unnecessary readmissions. ■

Dear *Discharge Planning Advisor* Subscriber:

This issue of your newsletter marks the start of a new continuing nursing education (CNE) semester and provides us with an opportunity to tell you about some new procedures for earning CNE and faster delivery of your credit letter.

Discharge Planning Advisor, sponsored by AHC Media, provides you with evidence-based information and best practices that help you make informed decisions concerning treatment options. Our intent is the same as yours: the best possible patient care.

The objectives of *Discharge Planning Advisor* are:
- 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.

The American Medical Association, which oversees the Physician's Recognition Award and credit system and allows AHC Media to award *AMA PRA Category 1 Credit™*, has changed its requirements for awarding *AMA PRA Category 1 Credit™*. AHC Media made the decision to make this change across all of our publications. Enduring materials, like this newsletter, are now required to include an assessment of the learner's performance; the activity provider can award credit only if a minimum performance level is met. AHC Media considered several ways of meeting these new AMA requirements and chose the most expedient method for our learners.

HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:

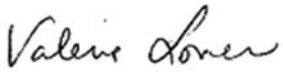
1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. You will no longer have to wait to receive your credit letter!

This activity is valid for 36 months from the date of publication. The target audience for this activity is social workers, case managers, and nurses.

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

On behalf of AHC Media, we thank you for your trust and look forward to a continuing education partnership.

Sincerely,



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