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IN THIS ISSUE

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AHC Media

Care transition intervention lowers health system's hospital readmissions

Coaches empower patients in self-care

Medicare spends about $17 billion a year on hospital readmissions that could have been prevented, experts say.

About one in five Medicare fee-for-service patients are rehospitalized within 30 days of being discharged from the hospital. In the best-functioning hospitals, about 5% to 8% are readmitted; in some hospitals, nearly one-third of Medicare patients have a readmission within 30 days post-discharge, says **Stefan Gravenstein**, MD, PhD, clinical director of Quality Partners of Rhode Island and professor of medicine and community health at Brown University, both in Providence, RI. Quality Partners is a nonprofit organization established to be a Medicare improvement organization for the state of Rhode Island.

Gravenstein and other researchers decided to test an intervention to reduce 30-day hospital readmissions among this population. It is based on the transitional care work and randomized controlled trial by Eric Coleman, MD, MPH, professor of medicine with the Divisions of Health Care Policy and Research and Geriatric Medicine with the University of Colorado, Denver.

The intervention involves having coaches meet with and call patients to empower them to access community providers when their symptoms begin to show trouble, rather than waiting until they are very sick and need to be hospitalized.

"Eric Coleman, who is a geriatrician and science professor, demonstrated a few years ago that if you taught patients basic skills, they could self-manage and speak up for health care when they needed it," Gravenstein says. "He called it the care transitions intervention and demonstrated that it resulted in more than a 30% reduction in readmissions among older patients."[1]

The logical follow-up to Coleman's work was to try the intervention in a

EXECUTIVE SUMMARY

- Care transition intervention results in 36% reduction in 30-day readmission rate of Medicare patients.
- Intervention follows model demonstrated by geriatrician Eric Coleman, MD.
- Coaches teach patients to use their common sense when experiencing symptoms.

real-world setting, which is what Gravenstein and co-investigators did in a new study that found a significant reduction in 30-day readmission rates for patients ages 65 years or older. Individuals who received the intervention had a 30-day readmission rate of 12.8%; those who did not receive any part of the intervention had a 20% readmission rate. And an internal control group of people, who declined to participate or who were lost to follow-up before having a home visit, had a readmission rate of 18.6%.[2]

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Executive Editor: Russ Underwood, (404) 262-5521, (russ.underwood@ahcmedia.com).
Associate Managing Editor: Jill Von Wedel, (404) 262-5508, (jill.vonwedel@ahcmedia.com).

EDITORIAL QUESTIONS

For questions or comments, e-mail Russ Underwood, russ.underwood@ahcmedia.com

In addition to educating patients and empowering them to be more proactive with their health care needs, the system needs providers to be ready to see patients immediately, in order to work, according to Gravenstein.

"The backdrop system has to be ready so when doctors get the phone call from patients, they can say, 'Yeah, we have a spot for you,'" Gravenstein says. "Hospitals have to notify primary care physicians and give them information that supports successful coaching."

"As a real-world intervention, we wanted to offer this to as many people as possible, given our resources," says **Rachel Voss**, MPH, program coordinator of Quality Partners of Rhode Island.

"We did find similar to Coleman's results a 36% reduction in the readmission rate when compared to people we had never approached about this intervention," Voss says.

The study selected a random sample of the targeted population, but was not designed as a randomized controlled trial.

"As a Medicare-funded pilot program, we hired coaches to work with six hospitals and work with any patient who was cognitively intact and discharged from the hospital to the community," says **Rosa Baier**, MPH, senior scientist at Quality Partners and a teaching associate at Brown Medical School.

The coaching intervention was based on the four pillars of Coleman's model: medication management, a patient-centered record that the patient maintains for transferring information to various providers, timely follow-up appointments, and watching for and responding to red flags or warning signs and symptoms.[1]

"The coaches do not do the work for the patient, but empower patients to take care of themselves," Voss says. "They guide people at home through medication reconciliation, and they teach them to reach out to their physicians so they can self-manage properly."

The intervention spans a 30-day period and has the coach make a hospital visit, a home visit within three days of discharge, and two follow-up telephone calls within the first week and the first four weeks post-discharge. Patients receive a booklet for recording their personal health record, including their main health problems, medications, and questions for their doctors.[1]

Coaches are not the same as nurses, Gravenstein notes.

"When you send a nurse to the home, the nurse may notice the patient has swollen legs, and the

nurse might have the patient increase the water pill," he says.

"Coaches, instead, help patients recognize when something is going wrong and how to reach into the provider system to get the help they need," he adds. "So if the coach sees the patient, and the patient says, 'My legs are swollen; what do I do?' The coach helps them reason through that problem and realize that it's okay to call the doctor and arrange for an appointment in the next couple of days."

Often Medicare patients will ignore their symptoms or put off a doctor's appointment until the problem is exacerbated and requires an emergency room or urgent care facility visit, Gravenstein says.

"They say, 'I can just wait,'" he explains. "For an 80-year-old with heart failure, that means a 911 call."

For purposes of the study, the coaches were nurses and social workers, Voss says.

"In theory, they don't need to be nurses because they're not supposed to use nursing skills," she adds. "We have other projects similar in style to this intervention where coaches are not nurses; they have some familiarity with the health care system, but they don't have the level of background as nurses, and they're still as effective at the intervention of empowering patients."

Coaches teach patients to use their common sense, Gravenstein says.

"If your toe is swollen, you don't need a nurse to tell you that your toe is swollen and somebody should take a look at it," he says. "You need common sense to say, 'I need to have someone take a look at this.'"

People who are health literate already have these self-empowerment skills, he adds.

"You want the patient to own these decisions about when to generate an encounter with the doctor's office," he says. "You're teaching them to fish rather than giving them a fish."

Outreach is a main skill patients are taught. Also, coaches push patients to make those appointments sooner rather than later, Gravenstein says.

"The coach's job is not to catch every problem that arises, but to teach the patient to recognize and do outreach for help when it arises," Baier says.

Patients receive the personal health record in the hospital where they are taught how to understand their medication list, Voss says.

"Patients write down the medication information in their personal health record, so when they get home they have a written record in their own handwriting that they can match up with all the bottles on their table and in their cupboards, as well as with their discharge instructions," she explains.

Patients can share their personal care journals with their community providers. This helps facilitate information transfer across health settings, so that providers have the right information about a patient's health status and recent hospitalization, Baier says.

They also can list their symptoms and warning signs in the record.

"It's a touch point for communication for health care providers," Gravenstein says. "Our role is to engage these various providers to make sure these things happen."

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- *Rosa Baier, MPH, Senior Scientist, Quality Partners of Rhode Island, 235 Promenade St., Suite 500, Box 18, Providence, RI 02908.*
- *Stefan Gravenstein, MD, PhD, Clinical Director, Quality Partners of Rhode Island, 235 Promenade St., Suite 500, Box 18, Providence, RI 02908.*
- *Rachel Voss, MPH, Program Coordinator, Quality Partners of Rhode Island, 235 Promenade St., Suite 500, Box 18, Providence, RI 02908. Email: rvoss@riqio.sdps.org.* ■

Improving collaboration with the community

Guidelines spell out responsibilities

Hospitals and home care agencies often collaborate on an ad hoc basis with little attention to standardized policies and procedures. When these collaborations are done poorly, they can lead to problems and readmissions, which is why Children's Hospital Boston decided to create guidelines for case managers working with home care liaisons.

"We had a meeting with a group of home care providers who talked about some problems with referrals they had received — not specifically from Children's Hospital, but in general," says **Erika Penney**, RN, MSN, CPNP, CCM, a nurse case manager at Children's Hospital Boston.

After the meeting, hospital leaders discussed the feedback and decided to put together guidelines for working with liaisons.

"We wanted to create our own guidelines, making it clear what our roles and responsibilities are when we're working with liaisons," Penney says.

Here is how the hospital created the guidelines:

• **Seek information and input from liaisons and staff**: "We started it informally by talking amongst ourselves and meeting with various liaisons," Penney says. "It took us somewhere between six and nine months to gather all the information, go through several drafts and considerations before we finalized our guidelines."

Everyone in the department was asked to provide feedback. In meetings, staff had conversations centered on issues with liaisons and common themes in what worked and what did not, she adds.

"These conversations led to us starting a formal process of asking for written feedback about the issues the hospital staff had with liaisons and what they wanted to include in guidelines," Penney explains. "We also gathered job documents from other case management colleagues to get a sense of how their job documents were written up."

They also met informally with members of the hospital's liaison team and networked with three other case management departments in the Boston area, she adds.

• **Focus on communication**: "Communication was a big component of where we felt things could fall through," Penney says. "People were not closing the loops and making assumptions the other person had done the work."

Someone might assume the case manager had done this task, and the case manager might assume the liaison had done it.

"We identified several themes that came out of our discussions," Penney says.

They found these characteristics common to a positive collaboration process at discharge:

- Hospital discharge staff and liaisons take time to learn each other's practices and backgrounds.

- They discuss and agree on each other's roles, responsibilities, and expectations in developing discharge plans and following through with the plans.

- They provide time for ongoing communication, including information updates, discussion of needs, and evaluation of progress.

- They recognize that the case manager or the liaison is responsible for various parts of the discharge planning process.[1]

• **Outline individual roles:** The key is to avoid misunderstandings about the individual roles during the discharge process.

"We created a grid that outlined the roles and responsibilities as described in our discussions," Penney says. "Some are the case manager's responsibility; some are the liaison's responsibility, and some have a shared component."

An example of a case manager's responsibility might be to monitor and evaluate the patient's readiness for discharge. An example of the liaison's responsibility might be to communicate individualized needs and the discharge plan to the agency, and an overlapping responsibility could be to collaborate with the care team regarding what is needed to ensure a coordinated plan.[1]

"It's the shared component that you have to be most careful about," Penney says. "You need to be careful about communicating this part when you are working together."

Overlapping responsibilities could even include more than one liaison working with a patient.

"We asked liaisons, 'If there are two home care agencies involved in a case, how would you view your responsibility toward talking to the other home care agency?'" she explains.

For example, there might be a home care agency that visits the patient, as well as an infusion agency. Does the infusion company call the home care agency's visiting nurse and explain which pump it's putting in the home and the range of the equipment?

"Some absolutely saw that as their responsibility and would not expect the case manager to do it," she says. "Others said it wasn't their job, and they expected the hospital case manager to take care of it."

That's why the guidelines include instructions for case managers to facilitate communication among liaisons, the medical team, and the patient

EXECUTIVE SUMMARY

- Seek input from home care liaisons when writing guidelines about the collaboration.
- Make communication issues a big part of the process.
- Define individual roles to avoid misunderstandings.

and family, she adds.

"We realized as an institution we could not predict what our liaisons would or would not do because we were not their employers," Penney says. "The guidelines we wrote were for case managers, informing them of what they needed to think about when they were working with liaisons."

• **Write job descriptions:** Discharge planning managers should write job descriptions for case managers and others involved in the process. They should ask liaisons for their own job descriptions and review these, as well.

They also asked liaisons questions about specific responsibilities, such as obtaining prescriptions for patients, Penney says.

Hospital case managers also have to be aware that their liaison collaborators have different job descriptions and expectations from their employers, so some of the guidelines might not always work perfectly in each liaison situation.

"This emphasizes all the more that we need really good communication in closing the loops, and also need to take time to get to know each other," Penney says. "We need to take time to get to know her practice style, finding out exactly what she is planning to do when she accepts a case."

And the case manager should clearly articulate her expectations for follow-up and provide guidance on how best to work with families, she adds.

• **Make thorough, but succinct, guidelines:** "We have a format at the Children's Hospital that we follow for guidelines," Penney says. "It's all outlined for us, and we have to write it in a specific order."

Following this standard format, the guidelines begin with a description of how hospital case managers work with community home care liaisons when coordinating their discharge plans for patients and families, Penney describes.

"We work with a multidisciplinary team to come to a consensus on what is necessary to get the patient home safely," she says.

"We speak to the liaison's role as vital in communication, and it helps us complete the needs assessment for the family and patient for problem-solving and specific interventions related to completing the discharge plan," she adds. "Effective communication and collaboration is necessary for care transition success."

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SOURCE:

• *Erika Penney, RN, MSN, CPNP, CCM, Nurse Case Manager, Children's Hospital Boston, Boston, MA. Telephone: (617) 355-2346.* ■

Leaders describe guideline creation

Staff are more careful now

Case managers at Children's Hospital Boston wrote a successful set of guidelines describing roles and responsibilities in the hospital's collaboration with home care liaisons during the discharge process.

The guidelines have resulted in hospital staff being more conscientious of the work they have to perform at discharge, and they're more careful with follow-up communication and verbalization of expectations, says **Erika Penney**, RN, MSN, CPNP, CCM, nurse case manager at Children's Hospital Boston.

"We had everyone in our department review the guidelines, and we came to a consensus of whether they seemed valid or reliable," she says. "Everyone agreed that what we'd written were aspects of the hospital's roles and relationships and were important to address."

Here are some of the key components of the guidelines:

• **Case manager's responsibilities.**

"We included the case manager's responsibilities when working with liaisons," Penney says. "Our case management director was very clear that she wanted us to include language explaining that ultimately the whole medical team is responsible for putting together a safe discharge plan, but the case manager has a pivotal role in it."

The guidelines clarify that case managers are responsible for communicating with the multidisciplinary medical team regarding specific discharge planning needs, she adds.

• **Meetings with patients.**

"We always meet with patients and families prior to initiating any referral," Penney says. "We get their informed consent and offer anticipatory guidance regarding any home services

they might need."

The guidelines include a line that discusses how the hospital makes referrals based on knowledge of all the different agencies and doesn't have preferred providers, she adds.

"It's our job to talk with the family about what's involved in getting skilled home care services, what they need to know and can expect and what we need to do before liaisons come in," Penney says. "Likewise, the case manager meets with readmitted patients and families to get their agreement on referrals to health care providers they had in the past."

Some insurance companies specify which providers can be used for these community services, so case managers will go over these limitations with patients and their families.

"We make sure to the best of our knowledge that if we know there's one agency that is an in-network provider versus an out-of-network provider, we present that to the families," Penney says.

When case managers lack preferred provider information, they ask the liaisons for more information.

"We will suggest to liaisons that they get back to us after their financial research into whether they can accept an in-network rate," she adds.

• Notify liaisons about referrals.

"We notify liaisons when patients are readmitted and families want to use them," Penney says. "We pass along any problems or concerns brought to our attention, and we work with community liaisons to make a plan together about communication and follow-up throughout the process."

Case managers make sure liaisons have all clinical documentation, and they are responsible for facilitating communication between the medical team and patient or family.

It's left to each case manager to decide how to facilitate communication. Some retain more control than others, Penney notes.

"Some will say, 'You must go through me directly rather than the doctor for communication,'" Penney says. "Other case managers are more comfortable delegating to the liaison than others."

Most members of the discharge team view liaisons as part of the multidisciplinary team, she adds.

Case managers also facilitate completion of all necessary documents for the care transition. They make sure the home care provider receives all of the information necessary on the patient's case and funding approvals.

"It's our responsibility to keep liaisons up-to-date on any changes in the patient's status that could impact discharge planning," Penney says. "We keep them informed about anything related to the timing of the discharge or its original plan."

• Reporting pending lab results.

This is a shared responsibility, Penney says.

Liaisons are licensed health care professionals who have access to chart records where lab results would be reported, she notes.

"If the home care agency is asked to draw labs, then they need specific information about which labs and whom to call," Penney says. "This is something that could be lost if the case manager is thinking the liaison will take care of it and vice versa."

Case managers are more involved in this follow-up than they might have been previously.

"Typically, case managers were not in charge of discharge specifics other than making sure the transition goes well," Penney says. "The physician in the community would take over and communicate with the home care agency or specialist."

But now it's the case manager's job to make sure the hospital's instructions to home care providers are made clear.

• Delegating to liaisons.

"Case managers can request that liaisons ensure communication with all agencies," Penney says. "If more than one agency is involved, they can verify the home care clinicians are scheduled for particular times when they're transitioning from the hospital to the home, and they can verify that equipment will be there."

While some case managers might prefer to handle these transition issues themselves, others could leave it to liaisons, she adds.

SOURCE:

• *Erika Penney, RN, MSN, CPNP, CCM, Nurse Case Manager, Children's Hospital Boston, Boston, MA. Telephone: (617) 355-2346.* ■

EXECUTIVE SUMMARY

• Guidelines describe case managers' responsibilities when working with home care liaisons.
• It's the case manager's job to set patient's expectations about skilled home care services.
• Case managers also take the lead in communication across the care continuum.

ACA initiative targets coordinating care

CMS bundles payments

The U.S. Department of Health and Human Services (HHS) has launched a new initiative to help improve care for patients from their hospital stay through their transition back to the community.

Hospitals, physicians, and other providers can apply to participate in a program called the Bundled Payments for Care Improvement initiative, which will align payments for services delivered across an episode of care rather than paying for services separately. The goal is to give hospitals and physicians incentives to coordinate care, save money for Medicare, and improve care quality.

The Centers for Medicare & Medicaid Services (CMS) initiative will bundle care for a package of services patients receive to treat a specific medical condition during the hospital stay and recovery from that stay. By bundling payments for these episodes of care across providers, there will be a greater incentive for various providers to coordinate care transitions and ensure continuity of care from the hospital to the community. HHS aims to reduce unnecessary duplication of services, reduce preventable medical errors, and lower costs.

The initiative is launched by the CMS Innovation Center, which was created by the Affordable Care Act.

Requests for applications (RFAs) outline four broad approaches to bundled payments. Providers can determine which episodes of care and which services will be bundled together. The initiative is the result of earlier demonstration projects that suggest the approach could save CMS millions. In one example, a Medicare heart bypass surgery bundled payment demonstration saved the program $42.3 million or about 10% of expected costs, and it saved patients $7.9 million in coinsurance. It also improved care and lowered hospital mortality, HHS officials say.

Organizations interested in applying for funding for Bundled Payments for Care Improvement must submit a letter of intent by Nov. 4, 2011, for Models 2,3, and 4. The Model 1 deadline was Sept. 22, 2011. For more information, visit the CMS website at http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html. Also, they can email CMS at BundledPayments@cms.hhs.gov.

For more information about the CMS Innovation Center, go to the website: http://www.innovations.cms.gov. ■

Transitional care pilot program shows promise

Communication at hand-offs improved

A nurse practitioner-led transitional care program has helped improve communication between hospital and community care providers and facilitated a timely transfer of patient information, according to a study of a two-year pilot project.[1]

"We developed this program so when patients get to the hospital, providers would have all of the necessary baseline information on the patients," says **Maria Tereza Lopez-Cantor**, MA, ANP-BC, CCRN, a nurse practitioner with Internal Medicine Associates — PACT at Mount Sinai Medical Center in New York, NY.

"The nurse practitioner serves as a consultant," Lopez-Cantor adds.

It's an intensive intervention, notes **Theresa Soriano**, MD, MPH, director of the Mount Sinai Visiting Doctors Program and director of the Mount Sinai Chelsea-Village House Call Program. Lopez-Cantor and Soriano were among the authors of a study on the program.

The Mount Sinai Visiting Doctors Program is a primary care practice that operates outside of the hospital. The transitional care program helped the practice bridge a communication gap between its physicians and hospital providers, Soriano says.

The program enrolled Visiting Doctors' patients who were admitted to the hospital. There was a daily census of seven to 25 patients admitted, Lopez-Cantor says.

"One reason we did this program was because our physicians are in the field all day, and by the time we made it back, many things might have happened with a patient in the hospital," she

EXECUTIVE SUMMARY

- Intensive intervention succeeds with nurse practitioner-led transitional care program.
- Program links hospital discharge team to Visiting Doctors in community.
- Communication improved as a result of the program.

explains. "And we couldn't discuss the patient with hospital physicians until the end of the day."

The study found that the program's financial implications were reassuring, although it had not reduced hospital length of stay and readmission rates significantly.[1]

"We failed to show statistically significant outcomes in terms of length of stay or readmission rates because these were very sick patients who were nursing home-eligible with multiple comorbidities," Lopez-Cantor says.

"We think there are improvements in costs because of the focus groups we ran for providers," Soriano says. "People said they felt more comfortable discharging patients home knowing we would be following up, and before this program we weren't able to see patients right away."

Other benefits included better medication reconciliation and medication adherence and improved patient and provider satisfaction, they say.

"Patients loved that there was someone they could identify who was following through with their care and that they didn't feel alone in the hospital — they had someone advocating for them," Lopez-Cantor says.

"One big benefit is having the planning and treatment goals continued after discharge with nothing lost along the way," Soriano says.

Initially, a grant funded salaries for two nurse practitioners for the program. When the grant ended, the hospital paid for one nurse practitioner position. The Visiting Doctors program began a new team-based approach, but the hospital continued with a revised transitional care approach.

Although the hospital was not able to bill for this transitional care service, it proved financially beneficial because it helped the hospital increase its net revenues because hospital staff were better able to document each patient's medical complexity, Soriano and Lopez-Cantor say.

"A patient might have been admitted for pneumonia, but he also could have diabetes and chronic obstructive pulmonary disease and dementia," Soriano explains. "This makes for a more complicated patient and results in greater payments to the hospital."

Physicians do not have time to find every medical problem a patient has experienced in recent years, so they base their documentation on what they see, she notes.

"Even the best-meaning hospital physician, looking in hospital charts, won't see two years of home visits we've been providing because these aren't documented in the system," she says.

The NP-led transition care program makes sure they have this kind of information. Also, as hospitals and community providers transition to electronic medical records, this communication issue might improve.

Here is how the transitional care program works:

• The nurse practitioner receives an alert when the patient is hospitalized.

"When patients of our program were hospitalized, we had two nurse practitioners who would be alerted, and they'd go into the hospital that first day," Soriano says.

When the Mount Sinai Visiting Doctors Program started the initiative, hospital providers had limited information about the patient's community care and advanced directives, so the NP would bring that information to hospital medical teams.

"We'd have communication put in the patient's chart in the hospital, listing the reason for admission, a medical list up-to-date, contact people, a code status, and next of kin," Soriano says. "Giving them this information was helpful in creating a channel of communication between the inpatient team and our program."

Once the patient is admitted to the hospital, Lopez-Cantor would find the hospitalist or attending physician and discuss the patient's case and discharge barriers. She'd also meet with the hospital's social worker for that floor.

• Nurse practitioner addresses social issues.

The NP also could facilitate a family meeting to discuss end-of-life issues or safe discharges between the hospital and community providers, she adds.

"From the very beginning we are in touch with the social workers to plan out the discharge for this patient," Lopez-Cantor says. "We give them information about home care, nursing services in place, safety issues in the home, and that sort of thing."

Also, if the patient has social issues that make it difficult to return home, then they could address that, as well during the hospitalization, she adds.

"I'd type up things that were going on in the home, like a family dispute," she says.

• The program facilitates medication reconciliation.

"We review all the medications the patient would be going home with so when the patient is discharged home, it would be a smoother transition," Lopez-Cantor says. "We review all the medications at home on the post-discharge visit to

make sure there are not mistakes or errors."

Occasionally, Lopez-Cantor has made a visit to the patient's home and found prescriptions still sitting on the dining room table two to three days after discharge.

"When I'm in the home I call in those prescriptions to make sure they get all the medication they need," she adds.

• Communication was thorough.

"A lot of the communication was face-to-face," Lopez-Cantor says. "I also developed a progress note, which I put in the chart as a summary of the patient, including all medical problems, all medications, advanced directives, lab work, and any significant test done on an outpatient basis that might contribute to better management of the patient in the hospital."

The improved communication also helped hospital staff prevent a duplication of health care services.

For instance, the hospital physician might decide to order a CT scan for a patient, and the nurse practitioner would inform them of a CT scan that already had been done on an outpatient basis, Soriano explains.

Lopez-Cantor also meets with patients and gives them a card with her contact information. She tells them to call her anytime.

"When I got back to my office, I did follow-up on the patient," she adds. "If there are any issues, I'll get involved, but I don't want to step on too many toes, so I'm there for support and on behalf of the patient and the program."

When the hospital plans the patient's discharge, staff can contact Lopez-Cantor and arrange a discharge visit to discuss who will be visiting the patient post-discharge.

"Most of the time I did the visit post-discharge," she adds.

The post-discharge visit usually took place within one week of discharge, and it often was done as a joint visit with a home health agency nurse, Soriano says.

"But for half the patients, there was no skilled nursing need, so the nurse practitioner was responsible for only transitional care that the patient had upon discharge," she says.

"One of the necessities for this program to work is having nurse practitioners, or it could be physician assistants, in this setting," Soriano says.

"We felt the clinical complexity of patients at baseline, who were hospitalized from our program, tended to be much sicker than regular patients, and we wanted somebody with a higher level of clinical experience," she adds.

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• *Maria Tereza Lopez-Cantor, MA, ANP-BC, CCRN, Nurse Practitioner, Internal Medicine Associates – PACT, Mount Sinai Medical Center, 1 Gustave Levy Place, Box 1087, New York, NY 10029. Telephone: (212) 824-7228. Email: maria.lopez-cantor@mountsinai.org.*

• *Theresa Soriano, MD, MPH, Director, The Mount Sinai Visiting Doctors Program, Director, The Mount Sinai Chelsea-Village House Call Program, One Gustave Levy Place, Box 1216, New York, NY 10029-6574. Telephone: (212) 241-4141.* ■

Hospitals can add a CPR self-taught course to DP

Study showed successful launch

The hospital discharge process for cardiopulmonary patients could offer patients' families and friends a video self-instruction course on cardiopulmonary resuscitation (CPR) that improves discharge education and has the potential to save lives.

"We piloted a program, offering CPR training to family members and friends of patients in cardiovascular resuscitation," says **Audrey Blewer**, MPH, research coordination, at the University of Pennsylvania in Philadelphia. The CPR training program is affiliated with the university's Center for Resuscitation Science, department of emergency medicine.

Trained assistants offered the training to family members during the afternoons and early evenings, when more family members and friends were visiting cardiac patients. "If somebody accepted the training, we took them to a private conference room and administered the kit," Blewer says.

The American Heart Association developed the video self-instruction tool, which shows people how to administer CPR. It includes a 25-minute video and a mini-mannequin that blows up into a half-torso, a replicated head and chest area of a person. When someone practices on the mini-mannequin with chest compression, it will make a clicking noise to show it is being compressed appropriately.

Also, people can blow into the mouth of the mannequin and cause the chest to rise.

Each patient would view the video with the trained assistant observing and answer questions. Then the assistant would help the trainee blow up the mannequin and begin the CPR practice. This process typically took 45 minutes.

"The mannequin is designed so individuals can practice chest compression," Blewer says. "They encourage people to push hard and fast in the center of the chest." When the chest is compressed adequately, there is a clicking sound.

The kit was designed for use by even elderly adults.

"We've trained individuals over 80, and almost anybody could do it without any problems," she says. "It's like a beach ball with the same mouth and stick cap on the mannequin."

Once trainees completed the CPR program, they were encouraged to take home the video and mannequin and share the self-taught course with their family members and friends.

Blewer and co-investigators conducted the CPR self-instruction video training program as a pilot study to improve discharge education about CPR. While hospitals could give patients and caregivers the CPR kit to view and use at home, there likely would be inadequate follow-through, she notes.

"The research assistant is there to make sure they don't run into technical difficulties," Blewer says. "One of the main points we wanted to show or conclude was that the hospital serves as a unique point of capture to train family members and friends in CPR."

The study followed participants after their self-instruction session and had them demonstrate CPR on a full-size mannequin, called the skill reporter mannequin, which is used in group CPR courses.

"This mannequin has a computer that tracks an individual's heart compression rate and ventilation quality," Blewer says.

The results confirmed that people had learned how to conduct CPR adequately, she adds.

The hospital has continued the self-instruction CPR training since the study ended. There is no retesting with the skill reporter mannequin, however, she says.

For hospitals to implement this program, it requires a steady supply — maybe 50 of the CPR kits and trained staff to serve the role of the assistance. The people working with patients undergoing CPR training could be nurses or some other discipline. Or they could even be well-trained volunteers, Blewer suggests.

SOURCE:

• *Audrey Blewer, MPH, Research Coordination, University of Pennsylvania, Center for Resuscitation Science, Department of Emergency Medicine, Philadelphia, PA. Telephone: (267) 239-1765.* ■

CNE QUESTIONS

1. What proportion of Medicare patients are readmitted to the hospital within 30 days of being discharged?
   A. One in six
   B. One in five
   C. One in four
   D. One in three

2. Which of the following was not a key component of the guidelines written by case managers at Children's Hospital Boston describing roles and responsibilities in the hospital's collaboration with home care liaisons during the discharge process?
   A. Meeting with patients
   B. Reporting pending lab results
   C. Delegating to liaisons
   D. All of the above were key components

3. The Mount Sinai Visiting Doctors Program and Mount Sinai Medical Center in New York, NY, studied an intervention for sick patients with multiple comorbidities. The nurse practitioner-led intervention resulted in some positive outcomes. Which of the following improvements did the study find?
   A. The benefits included better medication reconciliation and improved patient and provider satisfaction
   B. The intervention resulted in a significant decrease in length of stay and readmission rates
   C. The study found a $65 million cost savings over three years
   D. All of the above

4. True or False: Providence St. Peter Hospital in Olympia, WA, has developed a Consistent Care Program that enrolls patients who have mental illness, chemical dependency, and other chronic diseases, and has helped reduce emergency room visits and improved health care savings.
   A. True
   B. False

ED care program has better outcomes

Relies on Consistent Care Program

An emergency department (ED) program has helped reduce ED visits and has resulted in health care savings through targeting services to emergency department frequent fliers.

Patients enrolled in the program often have multiple health problems, including mental illness, chemical dependency, and other chronic diseases. Although these patients need continual monitoring and care, they often lack consistent primary care services when they are discharged from the hospital.

Providence St. Peter Hospital in Olympia, WA, has developed a successful program targeting these patients. Called the Consistent Care Program, it enrolls patients in a five-county region. The program collaborates with a non-profit coalition of rural and urban hospitals, providers, public health clinics, and community health centers.

"Not surprisingly, the large part of this population is inappropriately seeking medication, narcotics, analgesics, and they don't have a proper primary care provider relationship," says **Joe Pellicer,** MD, medical director of the emergency department at Providence St. Peter Hospital.

Physicians, physician assistants, and nurse practitioners give letters of introduction about the program to patients who have repeatedly used the emergency department as their primary health care option.

One of the letters might say, "You've been here five times in the past month, and we have a program that will help you establish a relationship with a single primary care provider. In exchange for that, we expect you will not keep coming back to the emergency department," Pellicer says.

"They're given the letter and they can sign that voluntarily or choose not to, as is sometimes the case," he says.

"If they choose not to, then we send them a letter that says we're sorry they have chosen not to accept our invitation," he adds. "But here is the deal: 'You are in the program based on your history, and a care plan will be written. You will not receive controlled substances unless there's a new emergency on top of your underlying condition.'"

The program includes an important monthly meeting for the physician in charge, a nurse coordinator, representatives from the local clinic, and sometimes representatives from the court system and mental

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

■ Hospital-to-community collaborations can result in better quality

■ Transitional care training improves staffing skills, attitudes

■ Brain injury discharges prove uniquely challenging

■ Use this strategy to identify best sub-acute care providers

health care system.

"I go to these meetings, as well," Pellicer says. "Between us there usually is somebody who knows this patient pretty well."

The meetings are an opportunity to share information about patients, who are told about these conferences in their letters.

"Their names are highlighted in our system," Pellicer says. "With a single click, the physician who sees them can bring up the care plan."

The electronic information might say that the patient is being seen at a particular primary care clinic and ask that the physician inform the patient that he or she must go to that clinic for pain medication.

"Many of these patients have chronic medical issues and chronic pain issues," he explains. "They are using the emergency department inappropriately; they want to be seen at 11 p.m. and can't be bothered with schedules and seeing someone in the daytime."

With the new program, ED clinicians will medically screen these patients, but they won't prescribe pain medication for chronic concerns. So if a patient has chest pain, he or she will be treated for chest pain. But the program's electronic red flag might note that the patient has been to the ED 10 times previously, always reporting chest pain, he says.

Physicians are trained to tell these patients that they won't be prescribing pain medication tonight, and patients will need to return to their assigned primary care providers. If the patient who typically complains of chest or back pain now has a broken arm, then the physician could prescribe a painkiller, but each case is a judgment call.

"There are a few famous examples of people with hundreds of ED visits — making it a full-time occupation of going from hospital to hospital, and no one is communicating," Pellicer adds. "We feel through a documentable system of establishing care with a primary care source, we can legitimately say, 'No, we're not doing this; these are chronic concerns, and you have a place to go that will address these concerns. This is not an emergency tonight.'"

The program has enrolled about 600 people and recently won a national award for safety and quality, called the NOVA Award. The American Hospital Association gives the award to hospitals that develop collaborative efforts to improve community health.

Since the program was begun in 2003, there have been a number of benefits, including cost savings, preserving ED beds for patients who are in greater need of emergency services, fewer clinician resources going toward frequent-flier patients who should have been seen at a primary care clinic, and better communication between hospital staff and community providers.

The program includes a patient care coordinator, who is a nurse who communicates with patients and makes sure they have a primary care provider. The patient care coordinator also helps with transitioning ED patients to the community through established communication and relationships with community psychiatric services, parole services, and holding monthly meetings with community providers.

"Patient care coordinators can pull up patients' visits and history for the past month and review their treatment options," Pellicer says. "They can contact patients and make a game plan to address inappropriate behavior."

While this program was designed specifically for the population who uses the ED for primary care and pain medication needs, it can be adapted for use with other chronic disease populations, Pellicer notes. ■