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New research highlights problem of substance use and rehospitalizations

Utilization is high among users

Researchers have found that patients who are diagnosed with a substance use disorder are about twice as likely to be readmitted to the hospital as patients without this diagnosis. These findings suggest that hospitals could intervene with substance use screening and programs designed to reduce subsequent hospital utilization.[1]

"This paper shows that those who have substance use disorders are more likely to be readmitted to the hospital within 30 days," says **Brian Jack**, MD, professor and vice chair in the department of family medicine at Boston University School of Medicine/Boston Medical Center in Boston. Jack is the principal investigator for the Project RED – Re-Engineered Discharge program.

"Reducing readmissions is a very high priority across the country," Jack says. "The amount of money that can be saved by reducing readmissions from Medicare is in the tens of billions of dollars, and there's a lot of interest in finding ways to do that."

The study finding a connection between substance use and readmissions is a secondary analysis, conducted on top of a Project RED study, says **Alexander Walley**, MD, MSc, assistant professor of medicine at the Boston University School of Medicine.

The original study, published two years ago, showed that a Project RED package of services reduced rehospitalization at 30 days, he notes.

"What we did was take the sample of general medical service patients from that study and reanalyzed data to see what the rehospitalization rates were for patients who had a substance use disorder diagnosis at discharge," Walley says. "What we saw was that patients who did have a substance use disorder diagnosis were rehospitalized more often and were more likely to be rehospitalized."

EXECUTIVE SUMMARY

- Study finds that patients with substance use problems are twice as likely to be rehospitalized.
- Other risk factors include depression, lack of insurance, comorbidities.
- Key is to screen for substance use and provide education and referrals at discharge.

The study controlled for other factors that can make someone at high risk of rehospitalization, including depressive symptoms, age, lack of insurance, and comorbidities, Walley says.

Their acute care utilization, which also included emergency department visits, was higher than the acute care utilization of patients who did not have the substance use disorder diagnosis, he adds.

The new study also found that 17% of the patients had a substance use disorder diagnosis.

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EDITORIAL QUESTIONS

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Substance use disorder diagnoses were based on discharge codes, and it's likely a portion of potential diagnoses were missed, he adds.

The 17% finding would suggest that close to one out of five patients likely have a substance use problem, says **Steven M. Vincent**, PhD, LP, Care Center director, behavioral health services at St. Cloud Hospital of St. Cloud, MN. The hospital is part of the CentraCare Health System.

"Anytime we're dealing with a health care concern that might impact one out of five inpatients deserves attention," Vincent says. "What we've done in our own hospital on this topic is use a set of protocols to observe for signs of alcohol or drug abuse and the potential for withdrawal [symptoms]."

Substance use is the latest in a series of identified risk factors for hospital readmission, Jack notes.

It joins the more commonly known risk factors of low health literacy, long lengths of stay (LOS), having comorbidities, and being older.

"Other papers we've published show that people who have depressive symptoms are more likely to be readmitted within 30 days," Jack says. "Also, patients who have a low score on the patient activation measure, which is a measure of their motivation and ability to influence their care, are more likely to be readmitted."

Screening tools

Patients at very high risk of readmission need some kind of intervention designed to follow them in the days after hospitalization to help them stay on track with their health, he says.

"It would be very helpful to have risk prediction scores to identify who those people are," Jack says.

High risk screening tools can help identify substance use problems, as well as other issues that could lead to hospital readmissions, says **Tom Sedgwick**, LCSW, CCM, director of social work at New York University Langone Medical Center in New York City.

"We screen patients within the first 24 hours to see whether or not they need further social work services," Sedgwick says. "We do a full psychosocial assessment, and the social worker could pick up on substance use problems during the assessment."

Patients' medical histories also can provide clues about substance use and readmission risk.

"We look at previous medical records to see what the patient was here for and whether there are any patterns," Sedgwick says.

At St. Cloud Hospital, a patient's medical history of substance use would suggest a need for an intervention to prevent readmissions, Vincent says.

"If they don't have known history of substance use, then we inquire about the volume and frequency of alcohol use or use of other drugs," he adds.

Patients' answers might trigger a request for a consultation with a mental health and substance use case manager.

"We have a specific case manager in our hospital whose area of expertise and scope of responsibility are patients with psychiatric and substance use disorders," Vincent says. "The real emphasis is on substance use and potential for withdrawal."

Substance use can affect patients' overall health, undoing any medical stabilization the patient gained while hospitalized, Sedgwick says.

"They'll come back to us if they go home and are drinking and fall or are not compliant with their treatment regiment," he says.

Integration of care is very important for these patients, says **Mirean Coleman**, MSW, LICSW, CT, senior practice associate with the National Association of Social Workers in Washington, DC.

"If a patient has a substance use problem upon discharge then they should be integrated into the community," Coleman says. "Make sure the patient receives a referral before leaving the hospital, and, if possible, have them make an appointment to see a doctor so there is some continuity of care."

When patients with substance use problems are repeatedly admitted to the hospital, it also might be a worthwhile investment to place them on a case management program in which they could be followed by a case manager, Walley suggests. *(See suggestions for handling discharge of patients with substance use issues, right.)*

"It would be worth the investment of resources to have a case manager who can get to know the patient and work specifically on preventing future hospitalizations," he adds. "A lot of times the person's substance use interrupts the normal process of people getting their basic needs met, such as housing, food, and going to medical care appointments."

This interruption leads to patients who fail to address their chronic health problems, and it leads to acute episodes that send the patient back to the hospital, he explains. "Not everyone who comes in one time with a drug or alcohol problem needs to have a case manager, but for those who are readmitted, it might be worth the cost," Walley says.

More hospitals will reach this conclusion once the Medicare financial disincentive for 30-day readmissions is fully implemented, he adds.

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Experts offer tips for tackling substance use

Goal: Prevent hospitalization

Hospital systems and care transition teams should take a close look at their practices regarding patients for substance use problems with a goal of improving screening and discharge planning to prevent readmission of these patients, experts say.

"This group requires substantial attention; they re-utilize at high rates," says **Alexander Walley**, MD, MSc, assistant professor of medicine at the Boston University School of Medicine.

Hospitals could include questions about substance use in any general hospital admission or high risk patient's screening.

"Most places do a high-risk screen on admission to see if the patient requires further psychosocial intervention, and substance use is just one more thing they could put on the screen," says **Tom Sedgwick**, LCSW, CCM, director of social work at New York University Langone Medical Center in New York City.

Also, hospitals that have targeted quality improvement programs, such as Project RED – Re-Engineered Discharge program, could include interventions for substance use. Programs like

EXECUTIVE SUMMARY

- Hospitals' quality improvement projects might focus on substance use as risk factor.
- Look for trends in patient readmissions, and target those more common problems.
- Provide overdose training and counseling to care transition staff.

Project RED have demonstrated success in lowering hospital readmissions, lowering emergency room use, and lowering costs, says **Brian Jack**, MD, professor and vice chair in the department of family medicine at Boston University School of Medicine/Boston Medical Center in Boston. Jack is the principal investigator for Project RED.

"There are now important policy implications for hospitals," Jack adds. "They will need to meet certain quality benchmarks in order to receive payments on an incentive program from insurers and others."

Since programs like Project RED are expensive, hospitals look for ways to focus and target them to specific patient populations that will benefit most, he notes.

"There is a lot of interest in developing risk models using administrative and clinical data that will accurately predict who is likely to come back for the purpose of identifying and targeting those individuals," Jack says.

As hospitals develop and use risk assessment tools, they should keep in mind recent research findings that substance use, like depression and low health literacy, is an important and independent factor associated with rehospitalizations.

"Project RED wasn't targeted at substance users, but we think substance users would benefit from Project RED just as non-substance users would," Walley says.

Walley and Jack were among the researchers who found that rehospitalizations are more common among patients with substance use disorders than among patients who did not have that diagnosis.

"If you discharged 100 substance users, there would be 63 utilizations at 60 days," Walley says. "Discharge 100 non-substance users and you have only 32 utilizations at 60 days."

Hospitals should follow best practice measures and look for trends in patient readmissions, suggests **Mirean Coleman**, MSW, LICSW, CT, senior practice associate with the National Association of Social Workers in Washington, DC.

"When patients are readmitted for the same type of problem, it's important to assess what is really going on here," Coleman says. "Screening tools could be administered to patients admitted through the emergency room to the hospital, and that would be one way to find out if there's a need."

Substance use screening for trauma admissions are routine at some hospitals, says **Steven M. Vincent**, PhD, LP, Care Center director, behavioral health services at St. Cloud Hospital of St. Cloud, MN. The hospital is part of the CentraCare Health System.

"Our functional health assessment that is done at intake involves asking a few questions about substance use, but it doesn't really go into depth unless there's something in the patient's history or current presentation or trauma indications that triggers us to do a more complete assessment throughout the general hospital," Vincent says.

Vincent and the other experts provide these strategies for incorporating substance use assessment and interventions in the hospital discharge process:

• **Screen patients for substance use problems.** Screening tools could be administered to patients who are admitted through the emergency department or are in general hospital populations. Social workers who have a certified clinical alcohol, tobacco and other drugs credential are well trained to identify this problem, Coleman says.

"The social worker can administer the screening tool and provide initial counseling regarding substance use during the hospital admission," Coleman says.

A depression screening probably should be automatic, and the patient also could be asked about alcohol use at that time, Coleman says.

Screening also could include looking at previous medical records to see if there are any patterns, Sedgwick notes.

"It's almost intuitive when you've been doing it a while," Sedgwick says. "You know the signs when you see them. If someone keeps coming back because they are falling or if an older person has a changed mental status and frequent falls, then these are things we have to consider as possibly related to alcohol use."

• **Arrange for a case management consultation.** A known substance use history might result in a case management consultation.

"A case manager can talk with the patient and sometimes the family when there's a substance use concern that the patient doesn't acknowledge, but the family is willing to discuss," Vincent says. "Out of that discussion, a determination is made whether we need to put the patient on an observation protocol to see if there are withdrawal signs during hospitalization."

Then, based on the case manager's assessment, the hospital's team will determine whether there should be a full chemical dependency evaluation,

he adds.

This assessment also can guide referrals and patient education, such as providing overdose counseling and referring patients to chemical dependency treatment, as needed. *(See story on substance use referrals, below.)*

"If that's done, then that will produce recommendations about what level of treatment, if any, is needed," Vincent says. "It's included in the patient's medical record and is included in discharge findings."

• **Educate patients and their families:** At the very minimum, discharge teams can educate patients and their families about risk factors for substance use disorders, Vincent says.

Discharge teams also can provide follow-up interventions, Sedgwick says.

"After discharge, we make phone calls to all of our patients within 48 hours," Sedgwick says. "We check on the patient at home and see if there are any problems."

Nurses making these calls discuss the discharge plan with patients and check on any potential problems, including substance use issues. When a problem is identified, they make a referral or recommendation with the goal of reducing the patient's risk of rehospitalization, he adds. ■

DP team needs overdose training, referral options

Brief interventions can work

Hospital discharge planning teams might increase their skills and referral options when dealing with substance use issues by giving staff overdose and counseling training. They also can improve patient care at discharge by adding more options to their referral choices for these patients, experts say.

Patients with substance use problems might be readmitted to the hospital because of accidental overdoses, so it's important to have staff trained to counsel patients who are high-risk substance users about the risks of an overdose, says **Alexander Walley**, MD, MSc, assistant professor of medicine at the Boston University School of Medicine.

"These can be brief interventions done by physicians, RNs, or health promoter advocates," he explains. "The intervention lasts 15 minutes or less, and it involves having a person screened and asking the patient questions about consequences and encouraging the person to cut back or stop their substance use."

These brief interventions also can include assessing patients' motivation to change, he adds.

"If they're not motivated to change, you can agree to disagree," Walley says. "You can say, 'I understand that you feel this is not a problem for you, but as your doctor, I'm very concerned because we think this hospitalization is related to your substance use.'"

Physicians or others doing the counseling can ask patients to seek help in the future if they change their minds.

"You can say, 'Meantime, if you continue to drink or use drugs, please do it in the safest manner possible,'" Walley says.

"That's where overdose training comes in: Teach them what safe drinking limits are, if it's alcohol, and how to handle pills safely at home by keeping them locked up and taking them as prescribed," he adds.

If the counseling session results in the patient saying he wants to make a change now but doesn't know what to do, then the physician, nurse, or case manager can ask him about what he has done in the past.

"If he says, 'I went to a halfway house or treatment program, but I only stayed clean for six months,' then you say, 'Six months is a good amount of time, so let's have our discharge team help you find a program similar to that,'" Walley suggests. "'So you should consider going back to that program or a similar program and have that six-month start and build on that rather than lose it.'"

The key to helping patients make the best care transition is to expand the discharge planning team's list of potential referral options and find the one that most suits a particular patient's situation.

For instance, there is a range of options that could begin with simple patient and family educa-

EXECUTIVE SUMMARY

- Hospital discharge options for substance users can vary widely.
- Brief interventions by MDs, RNs, or others can be good step in discharge planning process.
- Discharge staff could be trained in overdose training and counseling.

tion about substance use.

"On the medical-surgical floor, the next step could be anything from initiating a physician's statement about the need to commit the patient for chemical dependency treatment to educating the patient and family about possible alcohol misuse," says **Steven M. Vincent**, PhD, LP, Care Center director, behavioral health services at St. Cloud Hospital of St. Cloud, MN. The hospital is part of the CentraCare Health System.

Social workers can play an important role in these decisions and referrals.

"The social worker can refer the patient to appropriate referral processes in the community when the patient is [ready] for discharge," says **Mirean Coleman**, MSW, LICSW, CT, senior practice associate with the National Association of Social Workers in Washington, DC.

Social workers could make the referral to a substance use clinic or an outpatient facility or some private individual counseling or therapy session within the community. And there are many social workers who are certified to provide substance use counseling, too.

Discharging patients directly to a substance use rehabilitation program typically requires the patient taking the initiative, notes says **Tom Sedgwick**, LCSW, CCM, director of social work at New York University Langone Medical Center in New York City.

"A lot of rehab programs in New York require people to take themselves there and show that investment in treatment," he explains.

In some cities, there are home care nursing programs that have psychiatric nurses who are trained to handle patients with substance use issues, Sedgwick says.

"There would be a special program where the nurses know they have to follow these patients more closely," he says. "They have the right kind of training to serve these patients, and they try very hard to keep the patient from coming back to the hospital."

Follow-up referrals also could include recommending the patient attends Alcoholics Anonymous meetings, Vincent says.

If the patient needs active chemical dependency treatment, then the discharge team provides information on where treatment can be accessed.

"When patients are willing, we'll try to facilitate their discharge directly to a treatment program from our medical surgical unit as well as from our psychiatric units," Vincent says. ■

Emory trains students on discharge tasks

Goal to develop DP skills

Health care systems nationwide increasingly are focusing on the care continuum and discharge process as a focal point for improving care, quality, and utilization efficiency. So why shouldn't medical schools make it a priority to offer coursework related to the discharge process?

"This is an issue that has been identified in many health policy circles as one that is of great importance in terms of the overall health system," says **Manuel A. Eskildsen**, MD, MPH, CMD, medical director of long-term care at Wesley Woods Center of Emory University and an assistant professor of medicine in the division of geriatric medicine and gerontology at Emory University School of Medicine in Atlanta.

"Readmissions, poor patient communication, poor care coordination plague the American health care system," he adds.

As an educator, Eskildsen decided to do something about this problem.

"I identified it as something of interest and something we could do to improve patient care," Eskildsen says.

"We started this in 2009 with a goal of getting students to develop skills in discharge planning and communication," he adds. "The idea was to do this in a setting that merged some classroom teaching with real-life learning."

In speaking with peers around the country, Eskildsen has found enthusiasm for the idea of including care transition in medical education. The only question was, "What is the best way to do this?"

Elements of the curriculum

So Eskildsen designed a care transitions curriculum that deals with discharge planning

EXECUTIVE SUMMARY

- As health systems increasingly focus on the discharge process, medical schools should follow suit.
- Emory University School of Medicine has care transitions curriculum that includes online components.
- Students showed greater knowledge, competence, and high satisfaction at end of required course.

and communication, and it's a requirement for fourth-year medical students at Emory. Eskildsen and co-authors studied the use of the curriculum with 121 fourth-year Emory medical students who participated in a Senior Medicine rotation at either Grady Memorial Hospital, Emory University Hospital, or Atlanta VA Medical Center, all in Atlanta, between August, 2009, and April, 2010.[1]

The curriculum includes the following:

• Discussion of care transitions issues.

This section began with a lecture on transitions of care and why they are important.

"We gave students an initial didactic for an hour on the general concepts of care transitions," Eskildsen says. "One of the nice things about the program is that it limits face-to-face time to the beginning and end of the course, so it saves a lot of time for faculty, as well as students."

The care transitions section includes a definition of different post-hospital discharge options, a list of methods for improving care transition safety, and an explanation of why care transitions are so complex among high-risk populations.[1]

Students had access to a discussion board that highlighted some care transition challenges through a case study with discharge summaries for a patient with congestive heart failure. An online discussion group gave students the opportunity to report on the strengths and weaknesses of the patient's management. Then, students posted responses to at least two of their classmates' reports on this board.[1]

• Preparation of a discharge summary.

This section involves online instruction on how to prepare a discharge summary. It included a lecture online and the use of a discharge summary template based on a guide created by the Boston Association of Academic Hospitalists, which is offered in a toolkit from the Society of Hospital Medicine.[1]

"The discharge summary is an integral document to patient care, and that happens basically for all hospitalizations, so this form was pretty standard," Eskildsen says. "We tried to follow a formula that was relatively common in the discharge summary, and we tried to use a generic discharge summary that would be useful in a lot of places since these students will graduate and go on to residency programs in other places."

Students could select a patient they saw during their rotation and write a discharge summary for that patient. The summary was posted to the discussion board online, and students commented on each other's reports. Faculty also gave feedback online.[1]

Medical students wrote discharge summaries for actual patients, but these summaries were not included in the patients' charts, Eskildsen notes.

"We had them practice these skill sets and report back to the rest of the group in an online educational program called the Blackboard, which they all shared," Eskildsen says. "They removed any patient identifiers before putting them on the Blackboard for other students to review."

• Making a post-discharge phone call to patients.

Each student was asked to make a post-discharge phone call within a week of discharge to the patient who was the subject of the discharge summary. This call was based on a discharge checklist adapted from "Ideal Discharge for an Elderly Patient: A Hospitalist Checklist," issued by the Society of Hospital Medicine.[1]

The checklist describes elements of a safe discharge plan and could be used in short reports that students filed on the Blackboard.

Students were asked to document patient communication/conversations they had with patients at discharge. In this format they could talk about problems with patients, Eskildsen says.

"At the end of the month, we all met and went over best practices and discussed the unifying process," Eskildsen says.

Investigators looked at several outcomes of the project. For one, they found that student satisfaction with the module was high. About 97.5% of the students rated it good or better, Eskildsen says.

"We also rated the quality of the discharge summaries they prepared and found that 90% of students met the appropriate criteria for their discharge summaries," he adds.

In addition, medical students' self-confidence in handling discharge summaries improved, and their knowledge improved in the pre-test and post-test.

"They found a benefit in learning about this aspect of medicine," Eskildsen says. "One of the things they appreciated the most had to do with real-life skills like preparing the discharge summary."

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Cost-related medication underuse is big problem

Identify issues at discharge

There is a large body of evidence that some people will avoid taking medication to save money, and this can lead to acute episodes that land patients in the hospital. The key is to identify this and other silent obstacles at discharge and provide patients with solutions that will improve their care transition.

"I'm a hospitalist, and I practice inpatient medicine, so it struck me that inpatients might be a high-risk group of individuals, who are sicker on average, and who might provide a cohort for understanding that kind of behavior," says **Niteesh Choudhry**, MD, PhD, associate professor of medicine at Harvard Medical School in the division of pharmacoepidemiology and pharmacoeconomics, Brigham and Women's Hospital in Boston.

"We often prescribe medications to patients when they leave, and these are new medications, so this might be an opportunity to understand and intervene at the time of giving new medication prescriptions," he says.

Investigators surveyed a group of inpatients, focusing on people who had prescription drug coverage through managed care companies and large health insurers, he says.

"In essence, they have pretty good insurance, and even amongst these individuals one-quarter of them reported underutilization in the prior year," Choudhry says.

The study found that 23% of patients reported cost-related underuse of medications in the year prior to admission, and nearly all study participants endorsed at least one strategy that would make their medication more affordable. Plus, only 16% of the patients who were prescribed medication at discharge said they knew how much they would pay for it at the pharmacy, and almost no one had talked with their inpatient or outpatient providers about the costs of their new prescriptions.[1]

Researchers identified four different types of behavior that were attributed to cost-related nonadherence, including these:

- Patients did not fill a prescription because of cost.
- Patients skipped doses to make medication last longer.
- Patients took less medication than prescribed to make it last longer.
- Patients split pills to make them last longer.

Most of the people who underutilized their medication fell into the first category of not filling the prescription because of cost, Choudhry notes.

There are many other reasons why patients are nonadherent with their medication and treatment, including the logistics of not being able to access the pharmacy or doctor's office or feeling that the pill burden is too high. These also need to be addressed. But cost is one of the biggest factors, Choudhry says.

"There is a huge amount of literature describing this phenomenon, and what we've seen over and over and across health care settings is that the average adherence in prescribed therapies is the 50% to 60% range," he adds. "So we're left with this huge problem of nonadherence."

One way hospital discharge planners can address this problem is by talking with patients and families about both the therapeutic reasons for taking their medication as prescribed and the expected costs of the drugs. During this conversation, the discharge team might learn of potential adherence obstacles and can address them upfront.

"We need to ask patients whether they take their medication and how often they take their medication, and if they don't take their medication, we need to ask them what we can do to make that not happen in the future," Choudhry says.

"Recognize it's a problem, give patients more information, and communicate with patients, their community providers, and the inpatient team," Choudhry suggests. "This won't solve the problem or make them more likely to afford medication, but it will allow providers to reinforce the need for those medications that are especially important and allow for discussions about alternatives."

For example, the discharge team could help the patient reduce out-of-pocket spending by recommending switches to generic drugs when this alternative is feasible, he adds.

"If we know there's a generic drug that's much cheaper, and we know the patient won't take

EXECUTIVE SUMMARY

- Discharge team should address medication adherence, study says.
- Patients often fail to take medicine because of the cost.
- Putting resources into discussing this issue with patients at discharge can prevent rehospitalizations.

the branded drug due to costs, then bring up the generic option," he says. "Many large pharmacy chains have cheaper drugs that are all generics."

Patients might have to pay $4 out-of-pocket and cannot file this with their insurance company, but the cost is far less than their $10 to $30 copay for the branded drug.

"Sometimes, generic drugs are not an alternative," Choudhry says. "But I'd be willing to venture that if you forced many of us to think about medications, and we understood how difficult it is for patients to prescribe these then we might change our opinion about which branded drugs are essential and which are not."

Another strategy is for the discharge team, with collaboration with the outpatient provider, to do a medication review and look critically at the patient's expected pill burden once he or she returns home.

"You need to look at the medications at discharge in the context of other medications the patient already is taking," Choudhry says. "On average, people take 5.5 medications, which could cost them more than $700 a year in copays, which is a lot of money for people who might make $20,000 to $30,000."

This medication review also could result in taking some medications off the list because of redundancy or because a prescription was continued even after the symptoms or problem had disappeared.

Pharmacists either in the community or hospital could be involved in this process, as well, he says.

"Pharmacists are highly effective in interventions, so this doesn't have to be done by a physician," he adds.

For hospitals that have to use pharmacist time efficiently, one strategy might be to have pharmacist-led medication reviews for high-risk patients, including those who have conditions like heart failure that often lead to readmissions, Choudhry suggests.

"If heart failure patients don't take their diuretics or ace inhibitors, for example, then they're very likely to come back to the hospital," he says.

The hospital discharge team also could target other conditions that Medicare has selected as being at high risk for readmissions, including heart disease and pneumonia, he adds.

"The pharmacist could review existing medications and make sure patients understand why they are taking them," Choudhry says. "The pharmacist could talk with patients about the newly prescribed medications and tell them what to expect and what their costs might be."

Also, the pharmacist could give feedback to the team and help the team make choices, such as changing a prescription from an antibiotic that is extremely expensive and which the patient cannot afford to an alternative that will achieve the same outcomes.

"We want our patients to get better, and all of us do this work for that reason," Choudhry says.

"Often, what we do is help them get better by prescribing medication because we're pill doctors by practice," he explains. "But if we're not thinking about how they will use the medications when they leave the hospital then that undermines the efforts we're making to help them get better."

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Study focuses on asthma discharge outcomes

Standardization is needed

One of the key discharge priorities in care for children involves asthma. Poor patient compliance with medication and self-care can lead to acute episodes and extra emergency room visits and hospitalizations.

Asthma episodes result in about 200,000 hospital admissions in the United States each year, and their treatment costs more than $3 billion. Previous studies have shown that inappropriate treatment is a major contributor to acute episodes, so various national organizations have developed asthma guidelines, but too few hospital emergency department employees have heard of these.[1]

The Joint Commission has made the Children's Asthma Care (CAC) measures its only core mea-

EXECUTIVE SUMMARY

- Asthma episodes cost health care payers more than $3 billion.
- Study finds that children's hospitals are highly compliant with most of the Children's Asthma Care measures.
- Children's hospitals still have room to improve on the home management plan of care.

sures applicable to evaluate care for hospitalized children.[1]

So researchers at Phoenix Children's Hospital used the three CAC measures in a study of hospital compliance, based on data for 30 U.S. children's hospitals. Data came from more than 37,000 hospital visits by children with asthma, and taking place between 2008 and 2010. The CAC measures include CAC-1 which refers to relievers for inpatient asthma; CAC-2, which are systemic corticosteroids for asthma; and CAC-3, which is a home management plan of care.[1]

They found that there was a high hospital-level compliance with CAC-1 and CAC-2 quality measures, but more moderate compliance with having a home management plan of care. The study also found no association between CAC-3 compliance and emergency department visits and asthma-related readmissions.[1]

"Compliance with CAC-3 started at approximately 40% initially and topped off at 73% over three years," says **Rustin B. Morse**, MD, medical director for quality at Phoenix Children's Hospital, University of Arizona College of Medicine in Phoenix, AZ.

"There was no difference in readmission rates in that period of time," Morse says.

Despite the findings, home management plans of care for asthma patients represent an important part of the hospital discharge process, he says.

"It's hard to evaluate interventions performed at the hospital level to see who is doing better," he adds.

So researchers work with the tools and data they have available, and these include the readmission rates.

"Our 30-day readmission rate for asthma in this population is lower than the typical readmission rate quoted in the adult literature," Morse says. "But more needs to be done to evaluate readmission as a measure of quality in pediatrics."

Intuitively, health care providers would think that compliance with CAC-1 and CAC-2 would lead to better outcomes and care, but this cannot be proven in a study until data are available from hospitals that demonstrate poor compliance with these measures. Obtaining such data would be difficult because adult hospitals do not have to collect these particular core measures, he notes.

"Hospitals that are Joint Commission accredited have to choose core measures, but not that many nonpediatrics are choosing asthma core measures," Morse says. "So how do we measure the quality of care in community hospitals to make sure they're providing the same level of care as the children's hospitals?"

Morse and co-authors wanted to see if trends noted in the literature about adult chronic illnesses proved to be true for children and asthma. Among these was the trend of low compliance and whether compliance was associated with outcomes. However, for the measures involving treatment, the hospitals were highly compliant. So they measured the compliance with the home management plan of action, which was less than ideal, and compared that with readmissions and ED visits.

"There are challenges with quality measurement and proving improved health or outcomes,"

CNE QUESTIONS

1. A new study about substance use and a general hospital population found that what percentage of patients had a diagnosed substance use disorder?
A. 9%
B. 14%
C. 17%
D. 25%

2. Emory University School of Medicine has a care transitions curriculum, dealing with discharge planning and communication. To which group is it targeted?
A. First-year medical residents
B. Fourth-year Emory medical students who participated in a senior medicine rotation
C. First-year Emory medical students
D. All of the above

3. Researchers have identified a common behavior attributed to cost-related nonadherence. Which of the following describes this behavior?
A. Patients did not fill a prescription because of cost.
B. Patients skipped doses to make medication last longer.
C. Patients split pills to make them last longer.
D. All of the above

4. According to substance use researchers and social worker experts, which of the following might signal the need to provide substance use screening of a patient?
A. Patients displaying high irritability to treatment teams
B. Patients with rehospitalizations, particularly when related to falls and a changed mental status
C. Patients who refuse to eat when physically able
D. None of the above

Morse notes.

"If a hospital gives an aspirin to a heart attack patient, then the patient will have an improved mortality rate, but is this plan of care equivalent to that aspirin?" he explains. "Does it improve their clinical outcomes in some fashion, and should everyone be doing it? That was the challenge we faced."

What they found was that compliance for CAC-1 and CAC-2 was very high at all 30 children's hospitals, but compliance with CAC-3 was not. Nonetheless, they discovered no difference in hospital utilization.

"The home management plan of care makes perfect sense," Morse says. "Patients should be able to measure asthma and know what happens, so we're not saying they shouldn't do those things."

But the way this standard was measured, it did not appear to be linked to improved outcomes, he adds.

One thing hospital discharge planners should keep in mind is that children's hospitals already have very good outcomes in asthma care, and they demonstrate overall fairly high compliance in the three core measures.

"What's important to me is the flip side of that coin where there is plenty of care for children outside of children's hospitals, and whether these children were receiving these high levels of care," Morse says.

"Compliance in children's hospitals was so high that we could not determine whether improvements in compliance would be associated with improvements in outcomes," he adds. "But we should make sure that every child admitted to community hospitals is receiving the same level of care."

The next step from an asthma home management plan of care perspective would be to find out which parts of the plans of care are of greatest value, Morse says.

One part requires some type of arrangement for follow-up care, including a scheduled appointment or giving patients and families the name of a provider they can call, he says.

"Perhaps, as we think about the appropriate transition of care as we move from inpatient to outpatient, that bar should be raised higher," Morse says. "Hospital discharge staff might actually make the appointments for patients and make follow-up calls to them about the appointment."

This is improving the connection between inpatient and outpatient care and optimizing the patient's potential to get the same quality on the outside as on the inside, he adds.

Another point is that emergency department and hospital utilization might not be the only or best outcomes to be evaluated in asthma care for children, Morse says.

"There are plenty of other potential outcome measures than readmission rates," Morse says. "The exciting part of what we're doing now is beginning to think about what are the right outcome measures to think about quality of care at the hospital level for children."

For example, quality of life and productivity outcomes might be used.

"We need measures like the number of days of

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. ■

school a patient misses or days of work missed because the parent is taking care of the child," he says. "What types of functional measures can we implement in a reasonably feasible manner to identify who is providing the best quality of care, and that is not easy."

Measuring readmission rates is far easier.

"It's very difficult to sit down with a seven-year-old and ask them how they feel when they are running around the playground, so that's the next challenge," Morse says. "How do you balance time and the cost element and measure the process of care in the hospital and outcomes after discharge?"

REFERENCE

1. Morse RB, Hall M, Fieldston ES, et al. Hospital-level compliance with asthma care quality measures at children's hospitals and subsequent asthma-related outcomes. *JAMA*. 2011;306(13):1454-1460. ■

CMS approves 500 FQHCs

The Centers for Medicare & Medicaid Services (CMS) announced in late October 2011 that 500 federally qualified health centers (FQHCs) were selected for the FQHC advanced primary care practice (APCP) demonstration project. The goal is to evaluate the effect of an advanced primary care practice model, called the patient-centered medical home, on improving health, quality and coordination of care, and lowering the cost of care provided to Medicare beneficiaries.

Funded through the Affordable Care Act, the CMS Innovation Center will offer technical support to providers to improve their coordination of care and spread to others the lessons and best practices they've learned.

The APCP demonstration will assess the effect of Medicare paying a care coordination fee to participating FQHC practices for all care coordination and management services. The APCPs are required to offer enhanced access to care through expanded hours, same-day appointments, or priority appointments so patients do not need to seek more costly urgent care services. Also, the APCPs will use a team approach, including nurse coordinators, physician assistants, pharmacists, and social workers, to coordinate health care and other services. A physician or nurse practitioner oversee all services.

FQHCs can access core training modules on topics essential to performing as a patient-centered medical home, including patient-centered care, team-based delivery, use of data/performance feedback for continuous quality improvement, and improving care transitions.

Participating FQHCs will be required to implement practice changes necessary to transform into advanced primary care practices, and CMS will monitor each center's transformative progress by comparing readiness assessment scores at baseline with readiness assessment scores updated every six months.

For more information about medical homes or the program, visit the Innovation Center online at http://innovations.cms.gov/. ■