DISCHARGE PLANNING
A D V I S O R

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Re-engineering Discharge Process

[Editor's note: The Society of Hospital Medicine's Project BOOST seeks to improve the hospital discharge process and create safer transitions for adults by encouraging hospitals to create multidisciplinary teams, use proven tools, and work with mentors. In this issue of Discharge Planning Advisor*, we have several articles discussing Project BOOST and how it has helped some of its earliest hospital participants. In the November/December issue, there will be additional stories about the project.]*

Project BOOST has produced early, positive results for involved hospitals

Its tailor-made toolkit helps

The hospital discharge process is receiving the attention it deserves with a new national project that seeks to improve health care transitions for all adults in the United States.

The Philadelphia-based Society of Hospital Medicine's Project BOOST, which stands for Better Outcomes for Older adults through Safe Transitions, has become very popular and has achieved some success in its first year of inspiring and assisting participating hospitals with making discharge process changes.

"It's funded by a grant, and we at the University of New Mexico were one of several pilot sites," says **Percy Pentecost**, MD, assistant professor of medicine at the University of New Mexico Hospital in Albuquerque, NM.

The hospital's interest in Project BOOST stems partly from a recognition that hospital medicine has become very complex, and health care systems need to ensure a greater continuity of care when patients are discharged, Pentecost notes.

"I think back to when I was a kid and my father was admitted to the hospital," Pentecost says.

"His doctor admitted him in the hospital, saw him in the hospital, discharged him from the hospital, and provided great continuity of care," he explains. "Now a quarter century later, things are much more complex, and so we're trying to recapture this true continuity of care while dealing with more complexities in the system."

Project BOOST was developed with funding from the Hartford

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Foundation as a way to help hospitals implement system changes in their discharge process, says **Tina Budnitz**, MPH, senior advisor for the Society of Hospital Medicine. **(See story on how Project BOOST got its start, p. 52.)**

Discharge planning often is problematic for hospitals, and it's not because physicians and other health care professionals do not understand what the best practices are, Budnitz says.

"The gap is being able to change the system to implement those best practices," she explains. "What we have found when we looked at hospitals is there's a tremendous range in terms of who owns the discharge process and a tremendous range in terms of their resources."

Health care today costs too much, and the outcomes aren't as positive as they should be, another expert says.

"So, like any industry, we have to figure out how to do it better, faster, cheaper, and safer," says **Matthew Schreiber**, MD, medical director for hospitalist services for the Atlanta-based Piedmont Healthcare and interim chief medical officer for Piedmont Hospital.

"We need to make sure that everyone who interfaces with patients feels like they're responsible for making the patient's outcomes as good as it can be," he adds.

Project BOOST primarily looks at creating successful discharges, including preparation for discharge, Schreiber says.

For instance, an important piece of the project is a risk assessment form that addresses problem medications, depression, and other issues that should be considered at discharge, he says.

"The discharge process in hospitals is a scary time for patients," Schreiber says. "So, we have to fix the discharge process and make it safe for patients, because it's the right thing to do."

For example, a male patient who is highly medicated and has ample access to resources in the community won't be as much at risk as an older male patient who has no social support, 10 different medications, and three different medication problems, Schreiber says.

"BOOST is focused on discharge, but managing a successful discharge includes critically evaluating your patient population, selecting the patients you need to spend the most time on, and making sure someone is taking all the necessary actions to reduce patients' risk exposure," he adds.

Schreiber sees Project BOOST as a good way to start improving the discharge process and hospital outcomes.

"The reason we got involved was because I was interested in taking a very critical look at the entire spectrum of patient care and our process in the hospital," Schreiber says.

"We realized the discharge piece of the patient experience was pretty big and broken, and we'd have to do something to manage it," Schreiber

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Editorial Questions

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explains. "So BOOST fell out of the sky and had the paper tools to help you manage the discharge process and make it better."

Confronted with a choice of doing the foundation work from scratch or taking Project BOOST's tools and infrastructure, which had been developed with experts, it was an easy decision to participate in BOOST, he adds.

"We were interested in setting up a geographically designated hospitalist unit, which is fairly popular these days," Schreiber says. "With the hospitalist model we place the patient with the attending physician, so if the hospitalist is the attending on record, the patient is placed in the hospitalist's unit."

The idea is to put patients all in one location, he adds.

The old way of handling rounds had physicians rounding on 15-20 patients who were scattered throughout the hospital, Schreiber says.

Physicians would spend 45 minutes just walking to various patient locations, he adds.

With the hospitalist model, the hospital places patients with the attending physician, meaning the physician conducting rounds has all of his or her patients in one location.

"By putting all 15 patients in one location, you eliminate that 45 minutes of time, and it enhances the visibility of staff and patients," Schreiber says.

"The patient's perception is 'My doctor is very available to me, and I can reach him by sticking my head out in the hallway and saying I need him,'" he adds.

This change, instigated by Project BOOST, reduces the time spent on patient rounds, provides physicians with a greater sense of ownership over patients' care, and makes providers responsible for patients' transitions out of the hospital, Schreiber says. **(See story on more changes made through Project BOOST, in the November/December 2009 issue of *Discharge Planning Advisor*.)**

"One of the revolutions of BOOST is you have in the hospital care providers saying they're responsible for what happens to patients, even after patients have left the hospital," he explains. "That's a major shift in philosophy and ownership."

Both physicians and patients have expressed greater satisfaction since the change, he notes.

The University of New Mexico Hospital began working on its initial steps with Project BOOST last fall, including looking at process mapping, following patients during the discharge process, Pentecost says.

Process mapping can be very enlightening to an organization, he says.

"Everybody has their own perspective, and when you get everyone together in a room describing the process you have a 'eureka' moment of 'Oh, that's why you do that! I had no idea,'" Pentecost says.

It takes a while for a hospital to analyze, assess, and improve its discharge process, he notes. **(See story about how the University of New Mexico Hospital improved its discharge processes, p. 53.)**

"It's been a long process, and the project sets us up with a mentor," Pentecost says. "And the first thing we did was have a couple of conference calls with our mentor to discuss some of the foundation steps, such as assembling a team and acquiring administrative support."

The changes Piedmont Hospital has made as part of Project BOOST have been fully appreciated by patients, Schreiber says.

"They are more satisfied with their care, and they have better outcomes," he adds.

Physicians also are more satisfied because the changes have brought back what has been missing from their medical practice, he notes.

"Physicians haven't gotten much satisfaction out of practicing medicine [in recent decades] with all of the reimbursement changes,"

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Schreiber says. "This re-invigorates their passion for medicine and taking care of patients." ■

Project BOOST's evolution has led to DP changes

Hospitals form teams, change processes

Hospitals and health care professionals want to provide patients with safe, effective, quality discharges but often lack the resources necessary to make this process optimal.

The Philadelphia-based Society of Hospital Medicine's Project BOOST, which stands for Better Outcomes for Older adults through Safe Transitions, is one national effort that seeks to remove all barriers to better discharge planning and transitions for adults.

When the project began, the society rounded up experts to discuss best practices in the discharge process, says **Tina Budnitz**, MPH, senior advisor of the Society of Hospital Medicine (SHM) and director for Project BOOST.

"We found our members really need the tools to change their system," Budnitz says.

SHM's initial project, called "Safe Steps," was intended to improve discharge safety, partly through the development of a comprehensive risk assessment.

"Our findings from Safe Steps were there were a lot of systems out there that were, in fact, broken in terms of a smooth discharge process," Budnitz says.

Comprehensive planning about the discharge process was started on admission, and Safe Steps focused on putting together a comprehensive team of all people who contact the patient, including pharmacists, nurses, case managers, physicians, etc., she explains.

"Doing a comprehensive risk assessment at the time of admission helped get the patient ready for discharge," she adds. "It really helps get them ready in terms of allowing complete staff to have time to work with the patient to understand self-care instructions, reconcile medications before they leave the hospital, and spend time with family members/caregivers before they go."

One byproduct of Safe Steps was an overall improvement in patient care, Budnitz notes.

Safe Steps had focused on adults ages 65 and older, but this mandate soon proved to be a barrier.

"We learned it would be more efficient to roll out an intervention for all patients," Budnitz says. "If you can solve a problem for your frailest patients, then you probably can solve it for all your patients."

So SHM officials discussed this with the Hartford Foundation, and the foundation granted SHM $1.5 million to evolve the intervention and roll it out on a grander scale for all adult patients, she adds.

"It became Project BOOST," Budnitz explains. "If you solve the issue for your frailest patients, you solve it for all of them, so in all of our hospitals the target is the general adult population."

Project BOOST was founded with a multidisciplinary team of advisors, including health care leaders, insurance companies, and accreditation, nursing, case worker, and pharmacy organizations.

"We brought them all to the table and said, 'Tell us the best elements of what you have to offer, and can we come up with something that has all the best elements?'" Budnitz says.

Two goals were met:

"One, we wanted to come up with a clinical intervention and create a toolkit to help people implement that intervention," Budnitz says. "That was a platform on which to layer on many other interventions."

Secondly, Project BOOST focused on a system-change intervention.

"Project BOOST has a comprehensive implementation guide with project-planning tools and form letters," Budnitz says.

The tools include a form letter discharge planning advocates can send to their hospital administrators, saying, "This is why we should participate in this project," she adds.

There also is a worksheet for the team, assisting members in narrowing down their goals into specific objectives, worksheets for meetings, data collection tools, sample project timeline, and others, Budnitz says.

"We included all the things you could create and do on your own, but we're giving you a huge leg-up and jump start," she explains. "The feedback we received was that people couldn't have gotten started on the project for two years without the tools."

The tools came from the literature, as well as some that were brought to the table by the project's advisory board, Budnitz says.

The advisory board painstakingly went

through every form and critiqued them, helping with improvements and overseeing the forms being piloted at a few sites, she adds.

"Some of the feedback we received initially from the toolkit was, 'This is fabulous, but we're still overwhelmed,'" Budnitz says. "They said they could use someone to provide mentoring."

So Project BOOST formed a mentoring program, bringing participants together for a two-day training session, walking them through the toolkit, talking about the project's rationale, and discussing how to adapt tools to their particular institutions, she explains.

"We do a lot of work-around teamwork and discuss how it is they can function better as a team," Budnitz says. "They meet with a mentor and then get started on an action plan, identifying major milestones over the course of a year and what needs to be done in month one."

Participating sites meet with mentors by telephone every two months. They also share a listserv in which participants can have private conversations with each other about challenges in changing their discharge processes.

"The other thing we offer to our mentoring sites is we have a Web-based community area for them to share across sites," Budnitz says. "One site may say, 'I've developed a script for a 72-hour call,' and they'll post their script."

Each quarter, there's an all-site conference call for which sites can submit topics in advance.

Project BOOST has participating sites collect data for their own quality improvement or publication purposes, as well as for the project to collect aggregate information.

The data collection includes this information:

- What are the 30-day readmission rates?
- What are patient satisfaction scores?
- Did someone send data to the receiving physicians?
- How did communication and teach-back with patients/families go?
- How often are patients getting a discharge appointment that's comprehensive and focused to their particular risk level?
- What's happening in 72-hour follow-up calls post-discharge?
- Were adverse events prevented and how?

"We encourage sites to share data as widely as possible, and some will do that in peer review journals, and others will do it in less formal mechanisms, like a local paper or societal newsletter," Budnitz says.

Project BOOST is still collecting aggregate data but will publish results when the first year's data are complete, she adds.

"We've interviewed all six sites and are conducting periodic interviews to see how the system change is working," Budnitz says.

"There are two outcomes we're going for," she adds. "One is that ultimately we want to improve patient outcomes, and the other thing is to build capacity at every site and have teams that could be front-line army for all patient issues."

The project appears to be a success, Budnitz notes.

"We're seeing changes in patient satisfaction, and, anecdotally, we've seen places where we've averted adverse outcomes in discharge," she says. "We do have data from comprehensive interviews from the first six sites, and our intention is to write that up for a journal."

Also, additional hospitals have contacted Project BOOST about becoming participants in the third cohort. Although the project's initial funding is scheduled to conclude in the spring of 2010, Budnitz says the project will continue and a third cohort will be initiated next year. ■

Hospital's discharge process was improved

Here's how it was done

When hospital leaders decide to participate in Project BOOST (Better Outcomes for Older adults through Safe Transitions), they should prioritize their goals, first selecting some key discharge processes they'd like to improve and then focus resources and attention on those.

For instance, the University of New Mexico Hospital in Albuquerque, NM, chose a handful of areas on which to focus attention.

"There probably are 30 things we could have done to try and improve our discharge process, but we chose five," says **Percy Pentecost**, MD, assistant professor of medicine at the University of New Mexico Hospital.

The hospital worked to improve these areas:

1. Create better discharge paperwork.

"We felt we needed better, more user-friendly discharge paperwork for our patients when they leave the hospital," Pentecost says.

"We wanted something that would help them understand what happened in the hospital, why

they were there, and what the next steps would be to improve their health," he explains.

For example, the patient's discharge education should include details about warning signs regarding their particular illness and when to seek medical attention.

Also, discharge paperwork should communicate in clear terms what has happened in the hospital, leaving no ambiguity or uncertainty for the next care provider, Pentecost says.

The hospital's traditional discharge paperwork was too busy, and it sometimes could be more trouble than help when patients showed it to their primary care providers (PCPs), he adds.

"If the story is not communicated accurately, then it can lead to misconceptions," he explains. "If sparse data are included in the discharge paperwork and the patient doesn't have the same story in his or her head that we providers have in our heads, then they'll fill in the gaps inaccurately for their PCPs."

When discharge paperwork is filled out accurately and completely, and when it's explained clearly to patients, then it's less likely there will be problems, Pentecost adds.

However, the hospital's discharge paperwork, prior to Project BOOST, had evolved with various pieces patched onto it and so a fresh start was needed, he says.

One important change was to add a simple discharge checklist to the process for nurses to follow during patients' discharges. **(See story about developing the discharge checklist, in the December issue of *Discharge Planning Advisor*.)**

So far, the process to change the paperwork has been slowed by the hospital's plans to change its computer system, Pentecost says.

"That's a challenge that we didn't really anticipate the magnitude of a year ago, because things were supposed to happen quickly," he says. "We don't want to overhaul our paper system and then have to overhaul it again as an electronic format."

The optimal solution will be to create a new electronic version of the discharge forms that will be used when the hospital makes its transition to the new electronic system. This would save providers' time and steps, Pentecost notes.

2. Improve medication reconciliation.

The hospital's standard process has been for nurses to confirm that medication reconciliation has taken place and that patients have an updated list of their medicines, Pentecost says.

"What's happened in the ensuing months since we started using the nurse discharge checklist is we found our medication reconciliation process did not turn out an accurate list of home medications," Pentecost explains. "A lot of that has to do with glitches in the computer system, and so we've recently instituted a new process for medication reconciliation."

For instance, the medication list often doesn't reflect all of the discharge medicines added to the patient's prescription list and may list old and inaccurate prescriptions, he says.

The new system puts more responsibility on the provider rather than relying so heavily on technology, he says.

"We've been having the health unit coordinators print the discharge medicine list and make sure it all looks fine," Pentecost says.

Once physicians or other providers manually verify the medication list, a nurse practitioner or physician's assistant, who is providing medication reconciliation, will change the computerized list to reflect all changes made in the patient's medications at discharge.

"This is an example where in some ways the technology is adding complexity and has made it more work for us," Pentecost says.

3. Call patients within 72 hours after discharge.

"We plan to call patients 24 to 72 hours after their discharge," Pentecost says. "We haven't implemented this change yet, because we need to identify what our manpower needs will be to make these calls."

Post-discharge phone calls may be handled by nurse case managers, Pentecost says.

The issues with implementing this change include taking time away from the nurse case managers' other duties and finding extra funding to hire more nurse case managers, he says.

"Then we have to find people to take the job, receive training, and then get up to speed," he adds.

The chief benefit would be to identify problems and safety issues soon after patients return home.

"For those of us in internal medicine, I think most people would agree that we get more challenging patients because they are older, have more comorbidities, and oftentimes there are safety issues at home," Pentecost says.

4. Give patients a number to call after discharge.

"We wanted to identify a way for patients to call their providers after they were discharged,"

Pentecost says. "So, we've been successful in doing that, and it basically wasn't a high-tech solution."

Hospital leaders decided the most important thing would be consistency, so they decided to identify the floor from which the patient was discharged as the contact number, he says.

"If you went to the UNM hospital and were discharged and called the operator to speak with your doctor, the operator wouldn't be able to help you for complicated reasons," Pentecost says. "So, we identified several dead-ends for patients when they call back with problems, and so we decided to be consistent and have them call the floor from which they were discharged."

After taking the call, the health unit coordinator would contact the attending physician or whoever else might be able to help, he adds.

For instance, if a patient left his dentures in the room, the unit coordinator would contact the charge nurse to see if the nurse could locate them, Pentecost says.

If there's a medical issue or question, the unit coordinator would contact the physician on duty on that floor, and the physician would be the point person to handle the patient's concerns, he adds.

"If they can't figure out what else to do then they can always call the provider who discharged them," Pentecost says. "And if it was last week, and I discharged the patient but am no longer on service, then whoever replaced me will get the call."

The whole idea is to avoid having someone answer a patient's call and say, "No, that person's not here, so you'll have to go to the emergency room," Pentecost says. "The vast majority of call backs are easily resolved."

Since the call-back system was implemented, it has worked very well, he notes.

"We have not had the volume of calls we used to, and patients aren't showing up unexpectedly," he says. "Whether that's because we're doing a better job of our discharges or because of the discharge checklist or because we are just sort of more globally aware of the details, it's working."

5. Make certain hospital providers can contact PCPs.

Hospital providers need to have a way to contact patients' primary care physicians at discharge, Pentecost says.

"We want to make sure they're aware that their patients have been in the hospital and what the problems were and what the plan is," he explains. "We're still trying to work out this issue, because our patient population is inconsistent in their relationship with PCPs."

Hospital providers often have no one to contact because the patient doesn't have a regular primary care provider, he adds.

"We have a very good community health network that adopts the majority of our patients who come in without primary care providers," Pentecost says. "Our university system itself is so saturated, we can't absorb any more patients because we're short on doctors within the UNMH system."

So, the first choice for patients without a PCP is to refer them to a sister network, he says.

"It can take six to eight weeks before they can see a PCP for the first time, and so we have, independent of Project BOOST, started a discharge clinic where we will see patients and follow up with them," Pentecost says.

This clinic, which is funded by the university hospital for patients who have no other safety nets, will provide care until the patient is able to meet with a primary care provider in the sister network, he adds.

"We started that just prior to becoming involved with BOOST," he says.

"Really, I think the discharge clinic and getting involved in Project BOOST has helped us see where we don't do a good job of discharging patients, raising this as an issue," Pentecost says. ■

For the best outcomes, consider patients' culture

Knowledge, understanding help ensure adherence

In an increasingly diverse society, case managers must be aware of the cultural beliefs and practices of the people they serve in order to effectively coordinate their care and help patients or clients adhere to their treatment plan, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy & Associates, a case management training and consulting company.

"Cultural competency is essential to close the widening gaps of disparities in health care. When providers are knowledgeable, respectful, and responsive to the issues surrounding cultural diversity, positive outcomes are much more likely to occur," Mullahy says.

Refugees and immigrants cannot be expected to give up their cultural and religious beliefs when they come to this country, points out **Lucy Ricketts**,

director of public affairs and cultural and linguistic services for Passport Health Plan, a member of the AmeriHealth Mercy family of companies.

"It's all about negotiation. We can't force our members to shift their attitudes about health care, but we can negotiate and educate them so they receive quality care," she adds.

For instance, the Louisville, KY, area, where Passport Health Plan has its headquarters, also is home to a number of agencies that resettle refugees and immigrants, according to Estes.

In fact, students in the public school system of Louisville speak more than 100 languages.

"We have great relationships with the resettlement agencies and work closely with them, so when they tell us which new group of people [is] coming into the area, we start doing research on the practices and beliefs of that culture," Estes says.

The Louisville area has had a huge influx of Somali families in the past two years, Estes adds.

"We found out that the local obstetricians were having difficulty understanding Somali women and their feelings about labor and delivery and prenatal care. We did a lot of research on our own and sought the assistance of experts in the area to help the obstetricians come up with strategies for caring for these women," Estes says.

The health plan partnered with a local Somali-Bantu women's empowerment group to gain the trust of the women, learn about their religious and cultural beliefs related to labor and delivery, and share information about the American approach to pre- and post-natal care.

For instance, the Somali women were upset, because when they were admitted to the hospital for delivery, they didn't receive a meal.

"They told us that in Africa, it was very important to eat a large meal during labor so you'd have the strength to deliver," Estes says.

The health plan shared the information with the obstetricians in person during the health plan's annual cultural competency conference and in the plan's provider newsletter.

Passport Health produced audio and hard-copy versions of its booklet "Mommy & Me Basics" in the Somali-Bantu language and instituted a pilot project to educate the Somali-Bantu women on Western medicine standards of care. The women and a facilitator from the health plan read sections of the book and had an open discussion on the cultural differences in prenatal care, labor, and delivery.

Being aware of a member's cultural background helps case managers, disease management nurses, and health coaches come up with effective strategies to keep the member healthy, says **Trish Nguyen**, MD, senior medical director of medical operations.

For instance, while Vietnamese eat a lot of vegetables, they also enjoy salty soups and fatty foods such as pork legs, says Nguyen, who is Vietnamese.

"When the health coaches work with our Vietnamese members to help them manage their chronic illness, they are aware that although Vietnamese and others in the Asian culture tend to eat a diet high in fruits and vegetable, those fatty, salty soups could be interfering with their treatment plan," she says.

"This is very important, because they can use key words and messages that will resonate with that member. Telling them just to eat more fruits and vegetables is a very 'vanilla' message, and it may not be effective," she says.

Although Vietnamese tend to be thin, many also have abdominal fat that makes them more likely to become diabetic or die at an early age from heart disease, she points out.

"If our health coaches were not aware of this, they might take it for granted that since the clients are thin, they don't need to modify their diet," she says.

One of the keys to coordinating care with people of different cultures is to understand their beliefs and practices, so you can determine what will resonate with them, Nguyen says.

"Understanding a member's cultural beliefs and practices is important, because it impacts health outcomes. If a care manager doesn't understand the person's cultural background, they will have difficulty engaging with that person, whether it's on the telephone or face to face, and they may not be able to help the person modify his or her behavior," she says.

For instance, health care professionals who are trying to communicate something of importance to patients may infer that patients are resistant to the information, embarrassed, or even depressed if they don't make eye contact. However, in some cultures, direct eye contact is perceived as threatening and case managers should be aware of this, Mullahy points out.

"In some cultures, Asian and Christian African-American populations among them, pain and suffering are believed to redeem and purify. Understandably, therefore, a patient may be unable or unwilling to provide a truly accurate assessment of his pain," Mullahy says.

Native Americans consider wellness as harmony and balance among mind, body, and spirit, Mullahy adds.

"That kind of belief may present a challenge for a diabetic patient facing amputation of a limb. How can he be whole in his afterlife if he is buried without his leg?" Mullahy says.

Mullahy relates that in the case of the diabetic man who was reluctant to lose his leg, practitioners made arrangements to ensure that the limb would be buried in the same place as the patient after his death.

Latino patients tend to resist home health services because of a tradition that all of the elders' needs should be taken care of by family members, adds **Janice Crist**, RN, PhD, associate professor at the University of Arizona College of Nursing.

Case managers shouldn't think that their Latino clients are non-compliant if they refuse home health services or it doesn't work out, Crist says.

Crist has received a grant from the National Institutes of Health to produce a short film that can be used to educate Latino families about the benefits of home health care.

Crist advises case managers and home health nurses to spend part of each visit or conversation getting to know their Latino clients before starting care.

"One of the most important things that health care providers can do when working with the Latino population is to talk things over in a personal way, instead of being official and impersonal like they would be with patients in the Anglo culture," she says.

Achieving cultural competency is not easy, and while your organization may provide information, individual case managers should assume some of the responsibility for learning about and understanding the populations they serve, Mullahy says.

"Fortunately, much of this information is a mouse-click away," she adds.

Care managers should ask open-ended questions, rather than just telling the member what he or she should be doing, Nguyen adds.

"Care managers need to be able to engage and have rapport with the members. When they ask open-ended questions, the member's cultural beliefs and perceptions come out and can be addressed," she says.

For instance, the case manager may ask members to name their favorite foods, then they ask about what is in their diet to isolate and understand where to begin working with the member on healthy eating habits.

"People in certain cultures have menus in their diet that are high in fat and calories. The health coaches and care managers can help them find healthy alternatives to some ingredients, so the food tastes the same but is healthier," she says.

For instance, if a member with hypertension eats a lot of chicken noodle soup out of a can, the health coach knows that it is high in sodium and can work to find alternative foods, she says.

"These open-ended questions can help the care coordinator or health coach discover the member's beliefs and understand why he or she isn't compliant," she says. ■

Sometimes DP has no great options

Experts offer advice on planning

Sometimes health care professionals involved in the hospital discharge process have no great options for transitioning patients, particularly when the patient is undocumented and/or uninsured.

This is why hospital discharge planners should come up with a plan that includes all available options for handling such unfortunate cases, well before this sort of case occurs on their turf.

For instance, hospitals in rural and remote areas where there are fewer charitable health care institutions or group homes that might take over the care of an indigent, uninsured patient, could seek help from an organization outside their immediate area. But hospital discharge planners would need to develop relationships with these outside organizations well before the ties are essential.

"I don't envy discharge planners in their efforts to find alternatives," says **Linda S. Quick**, president of the South Florida Hospital & Healthcare Association of Hollywood, FL.

Another key strategy is to have early and multiple conversations with the patient's family or guardian about their expectations and the reality of what is available for discharge, Quick says.

"I think ideally you have to start having a conversation with the patient as soon as they're competent to have that conversation," Quick says. "Or, from the get-go, speak with the patient's family, friends, neighbors, and anyone who appears to have a relationship with the patient."

Hospital discharge planners should explain that the hospital is ill-suited to be a residential

facility, so an acceptable discharge plan should be made, Quick adds.

Health care professionals should keep at least these three things in mind as they prepare for a discharge of an undocumented and/or uninsured patient, Dwyer says:

1. The patient's safety: "Is this a safe discharge plan?" Dwyer says. "Sometimes hospitals are deceiving themselves and will arrange a repatriation of a patient, saying they're sending this person to the rehabilitation hospital in Guatemala, but the truth is they know the patient will be there only a couple of weeks, and then that hospital will discharge the patient to the family."

Everyone involved in the discharge process should ask a series of critical questions regarding the patient's safety, he adds.

2. Fair share of uncompensated care: "Hospitals should ask themselves whether they are taking on a fair share of this uncompensated care," Dwyer says. "Sure, the hospital has to meet its margin, but they also have to meet their accreditation requirements."

If the current recession forces hospitals to take on too much of the burden of uncompensated care, then it might be time to find a public and political solution, he notes.

Health care reform, which doesn't address care for illegal immigrants, could at least help citizens who are uninsured find health care coverage.

3. Long-term solutions: "I'd also have discharge planners ask themselves whether they're working for a long-term solution to the problem," Dwyer says. "Of course, they have to deal with the immediate case, but when immediate cases are dilemmas for hospitals, it's because the overall solutions are out of whack."

This suggests that a hospital's discharge planning has not been as thorough in anticipating problems as it should be, and more preparation and imagination are needed. ■

Reduce one-day stays when observation is better

Transitions were not optimal

Hospitals sometimes fail to transition patients to the optimal level of care, which can create issues with quality of care and reimbursement.

A recent quality improvement project found

CNE *questions*

5. An expert says the hospital discharge process is often problematic for which of the following reasons?
   A. Physicians and other health care professionals do not understand what the best practices are.
   B. It's very difficult to change the system to implement best practices.
   C. Everyone is satisfied with what their particular discharge process can achieve.
   D. All of the above

6. Hospitals participating in Project BOOST, collect which of the following data:
   A. What are the 30-day readmission rates?
   B. How did communication and teach-back with patients/families go?
   C. Were adverse events prevented and how?
   D. All of the above

7. Which of the following processes would not be a good and effective way to improve the discharge process, according to Percy Pentecost, MD, at the University of New Mexico?
   A. Call patients within 72 hours after discharge.
   B. Make certain hospital providers can contact PCPs.
   C. Ask families to read discharge instructions to patient and teach patient about them.
   D. Create better discharge paperwork.

8. When hospital discharge planners are faced with a problematic discharge, such as a patient who has no payer source and limited options, which of the following questions should they ask themselves?
   A. Is this a safe discharge plan?
   B. Is the hospital taking on a fair share of the uncompensated care?
   C. Are we working for a long-term solution to the problem?
   D. All of the above

Answers: 5. B; 6. D; 7. C; 8. D.

that most one-day stays in a hospital were related to patients having chest pain symptoms. And many of these one-day stays originated in the emergency department and were unnecessary, an expert says.

The project found that patients were transitioned inappropriately, leading to higher costs and Medicare claims denials.

"We worked with 17 hospitals in a process improvement effort," says **Mary Helderman**, RN, CPUM, an oncology nurse in Terre Haute, IN. Helderman wrote a quality improvement report on one-day stays when she was the project coordinator for the Hospital Payment Monitoring Program (HPMP). HPMP, which had the goal of measuring, monitoring, and reducing the incidence of improper fee-for-service inpatient acute care Medicare payments, was disbanded in August 2008.

"We took a sampling of patients from the 17 hospitals and found that 79.9% didn't meet admission criteria," Helderman says.

"So that's a large percentage, and the estimated overpayment for those amounted to over $600,000," she adds. "When we looked at charts at three different intervals for 17 hospitals, there was an estimated overpayment of $1.5 million over a two-year period."

The baseline sampling was retrospective, and the other two samples were done before the claims were submitted, she says.

The idea was to have physicians clearly write whether they wanted a patient to have an observation stay or to be admitted to the inpatient acute area, she says.

"We found that maybe when the physician would write an admit to outpatient care, the person registering the patient would see the word 'admit' and interpret it as an inpatient stay," Helderman explains.

The problem could be the forms made the patient's transition unclear, or that people were not looking as closely at the forms as they should, he says.

Some hospitals seeing this report decided to implement a case management team in their emergency departments, Helderman says.

Other smaller hospitals implemented weekend coverage of case management to catch inappropriate inpatient stays before Monday morning, she adds.

"Others focused on education, educating staff on the difference between an inpatient stay and an observation stay, and they gave staff information about payment and denials," Helderman says. "Some started focused monitoring on inpatient stays to see where the gaps were in the process and to implement some changes there."

And some hospitals did concurrent chart reviews, rather than wait until patients were discharged to review their charts, she adds. ■

SOURCE

For more information, contact:

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CNE objectives

To earn continuing education (CNE) credit for subscribing to *Discharge Planning Advisor*, CNE 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. ■

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Extra diagnostic testing can cost hospitals big

Pay close attention to patients' resource utilization

Hospitals are losing large amounts of money on extra and inappropriate diagnostic testing and procedures, as well as outpatient procedures performed in the inpatient setting, because third-party payers frequently are denying the claims, says **Brenda Keeling**, RN, CPHQ, CPUR, of Patient Response, a Milburn, OK, health care consulting firm.

"Case managers should be on the lookout for unnecessary resource utilization, because their hospitals aren't going to get paid for it. If they see something in the chart that might be questionable, they should query the physicians about it," she says.

"Often patients come in with one acute care diagnosis and the physician orders diagnostic testing for other complaints that have no correlation to the acute care condition that prompted the admission," Keeling says.

For instance, a patient may come in with pneumonia and complain of having back pain for six months, so the doctor orders an MRI. The chronic back pain has nothing to do with the acute reason the patient is hospitalized, so the hospital is utilizing expensive resources for which there will be no additional reimbursement, she adds.

MRIs of the extremities or the spine for chronic pain rarely can be justified in the acute care setting unless the patient was recently injured, Keeling says.

Another example would be a patient who comes to the emergency department with a possible gastrointestinal bleed, is hospitalized, and receives an esophagogastroduodenoscopy (EGD).

"If the patient is asymptomatic, has a stable hemoglobin and a stable hematocrit, and isn't throwing up or passing bright-red blood, an inpatient EGD may be questioned by the payers and may not be reimbursed. According to Medicare, once the patient is stable, he or she can be worked up on an outpatient basis," Keeling says.

Other times, doctors will order the same test on subsequent days when the results of the first test are within the normal limits and the patient is asymptomatic, such as ordering a complete blood count several days in a row for patients hospitalized with GI bleeding, Keeling adds.

Case managers should review the charts of all patients daily, regardless of payer source, and make sure that the procedures the doctor orders are necessary for the patient's condition. ■

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