Healthcare

VANTAGE POINT®

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Hospital Discharge: Revamping Processes, Reducing Readmissions

Discharging patients from an acute care environment to the home setting is a complex process, requiring vigilance regarding such issues as handoff communication, medication reconciliation, follow-up and in-home support. Lapses in these and other critical areas complicate one in four hospital discharges for common diagnoses, such as congestive heart failure, renal failure and schizophrenia, and often lead to preventable readmissions.

At a time when Medicare is imposing high monetary penalties (totaling $566 million annually) for preventable readmissions through its Hospital Readmissions Reduction Program, hospitals are well-advised to evaluate their discharge procedures, especially in terms of the following areas:

- **Delegation of discharge tasks** to specially trained, dedicated personnel.
- **Assessment and communication of unresolved problems** to subsequent providers at the time of discharge.
- **Patient education** regarding medications and other therapies.
- **Discharge documentation formats,** including medication reconciliation.
- **Post-discharge patient compliance,** including drug therapy monitoring.

In this issue…

With the help of national initiatives – such as Project Re-Engineered Discharge (Project RED), which focuses on revamping key transition processes – hospitals are seeking to lower preventable readmissions. (For more information on the 12 steps of a reengineered hospital discharge process, see "Project RED: Twelve Steps Toward Safer Hospital Discharge," page 3.) However, according to a recent hospital-based study, the redesign process requires a sustained commitment and significant resources to achieve long term success.

This edition of *Vantage Point*® offers a range of measures to retool the hospital discharge planning process and increase awareness of post-discharge care directives. These measures are organized into five major strategies:

1. Analyzing root causes.
2. Preparing for the discharge process.
3. Utilizing discharge advocates.
4. Implementing strategic after-hospital care plans.
5. Strengthening communication with other providers.

1. Determine the root causes of readmission.

The first step in reengineering the discharge process involves identification of systemic problems that may affect readmission rates. By performing a root cause analysis and/or a failure mode and effect analysis, healthcare professionals can reveal flaws and gaps within hospital processes and systems.[1] Figure 1 (below) lists some potential discharge-related errors, according to their origins.

Every organization has its own discharge-related issues and challenges. However, certain risk factors are more prevalent than others, including these relatively common vulnerabilities:

- High-risk hospital treatment (e.g., surgery, dialysis, post-coronary artery bypass grafting).
- High-risk medical conditions (e.g., heart attack, pneumonia, stroke, cancer, bariatric weight loss, depression).
- High-risk medication use (e.g., antibiotics, glucocorticoids, anticoagulants, narcotics, anti-epileptic medications, antipsychotics, antidepressants, hypoglycemic agents).
- Multiple chronic conditions (e.g., advanced chronic obstructive pulmonary disease, diabetes, heart failure, obesity, substance abuse).
- Polypharmacy (i.e., five or more medications prescribed simultaneously).
- Unplanned hospitalizations within the preceding six to 12 months.
- Low level of health literacy.
- No designated primary care provider.
- Isolated lifestyle (e.g., family estrangement, remote residence, no telephone).
- Cultural differences between patients and providers, and related communication issues.

Ultimately, safe discharge involves an analysis and mitigation of the clinical system factors that predispose patients to readmission. In addition, the patient's unique constellation of psychosocial, logistical and economic factors must be considered. The following instruments, among others, are designed to help healthcare professionals conduct a comprehensive review of patients at the time of discharge, as well as estimate the potential for adverse outcomes:

- The *"8 Ps" Risk Assessment Tool*, issued by the Society of Hospital Medicine's BOOSTing Care Transitions Resource Room, focuses on certain conditions that potentially may lead to excessive readmissions and consequent Medicare/Medicaid sanctions.
- The *Hospital Guide to Reducing Medicaid Readmissions: Toolbox*, issued by the Agency for Healthcare Research and Quality, offers a readmission risk tool, a holistic assessment tool and a checklist of information to be communicated between providers.
- The *LACE Index* incorporates a patient's **l**ength of stay, **a**cuity level, **c**omorbid illness factor and **e**mergency department visits in the last six months.

Figure 1 – Common Sources of Discharge-related Error by Origin

Hospital-related sources:	Patient-related sources:	Clinician-related sources:
• Failed communication between patient and physician(s) of record. • Discharge summary not sent to primary care provider. • Lack of timely follow-up. • Failure to incorporate community services. • Inadequate patient education. • Medication-related error. • Untimely discharge due to financial or insurance factors.	• New medical problem. • Worsening known medical problem or post-treatment complication. • Drug/alcohol use. • Failure of patient to schedule or keep medical appointments. • Adverse drug reaction or interaction due to patient noncompliance with prescription guidelines. • Language and/or cultural barriers. • Low level of health literacy.	• Failure to review abnormal lab/diagnostic test results. • Lab result not acted upon. • Inappropriate discharge. • Failure to participate in discharge. • Lab test error. • Patient not seen before discharge. • Rushed and haphazard discharge process, due to excessive staff burdens.

1 For a description of such an analysis, see "Does Every Hospital Admission Deserve a Root Cause Analysis?" *NEJM Catalyst*, October 18, 2017.

2. Prepare for the discharge planning process upon admission. Optimally, the discharge planning process should begin at the start of the hospitalization, during the admission interview, when useful data regarding medical history, attempted therapies and successful interventions are initially captured. Early intervention is especially important for patients presenting with complex care needs. Such patients require input from multiple parties, including the patient and family, clinicians, physical and occupational therapists, social workers, case managers and insurance plan representatives.

By initiating the following measures upon admission, hospitals can enhance the discharge planning process and strengthen patient rapport:

- **Provide the patient, family and/or individual responsible for the patient's care (i.e., a third party with power of attorney for healthcare) with an expected time frame for discharge** whenever possible, providing updates as needed.
- **Arrange for a case manager or social worker to speak to the patient** as soon as possible after admission.
- **Contact the patient's health insurer** to determine service entitlements and eligibility criteria for outpatient services.
- **Assess existing barriers to care** that may prevent discharge to the patient's home, such as narrow doorways or stairs.
- **Identify any special needs** that will probably continue beyond hospitalization, such as assistance with activities of daily living, medication administration or transportation.
- **Compile a list of durable medical equipment requirements,** and discuss equipment and general care concerns with the patient and family.
- **Begin the process of identifying nearby aging services organizations,** in the event that short- or long-term subacute or rehabilitative care is needed.

A formal discharge planning protocol can help emphasize early intervention by assigning roles and responsibilities to a multidisciplinary team, including physicians, nurses, case managers, therapists and other ancillary members.

Project RED: Twelve Steps Toward Safer Hospital Discharge

Project RED (Re-Engineered Discharge) is the work of a research group at Boston University Medical Center, which develops and tests strategies to improve the hospital discharge process. Funded in part by the Agency for Healthcare Research and Quality, RED focuses on 12 mutually reinforcing actions that hospitals can undertake during and after the hospital stay to facilitate safer and smoother transitions:

1. Ascertain whether the patient requires language assistance, and provide as needed.
2. Make appointments for follow-up medical care and post-discharge diagnostic tests/labs.
3. Designate follow-up responsibility for lab tests or studies that are pending at discharge.
4. Organize post-discharge outpatient services, and arrange for delivery of medical equipment.
5. Identify correct medications, and create a plan for the patient to obtain and take them.
6. Reconcile the discharge plan with national guidelines, when available.
7. Draft a written discharge plan that the patient can understand.
8. Educate the patient about his or her diagnosis.
9. Assess the patient's understanding of the discharge plan.
10. Ensure that the patient knows what to do if a problem arises.
11. Promptly convey the discharge summary to clinicians who care for the patient.
12. Reinforce the discharge plan by telephone.

To learn more about the 12 components of an enhanced hospital discharge process, and to obtain help in achieving compliance with these guidelines, visit the Project RED website. Project RED also offers the following specialized tools, among others, to assist hospitals in reengineering the patient discharge process:

- *"How to Begin the Re-Engineered Discharge Implementation at Your Hospital."*
- *"How to Deliver the Re-Engineered Discharge at Your Hospital."*
- *Project RED Toolkit.*

3. Utilize discharge advocates.

Discharge advocates are specially trained to work closely with patients, families and other staff members to reduce preventable readmissions. Advocates are responsible for such essential safeguards as medication reconciliation, follow-up appointment coordination and communication of after-care requirements to network providers. Figure 2 (below) depicts the core activities of discharge advocates in relation to every stage of the planning process.

Quick Links

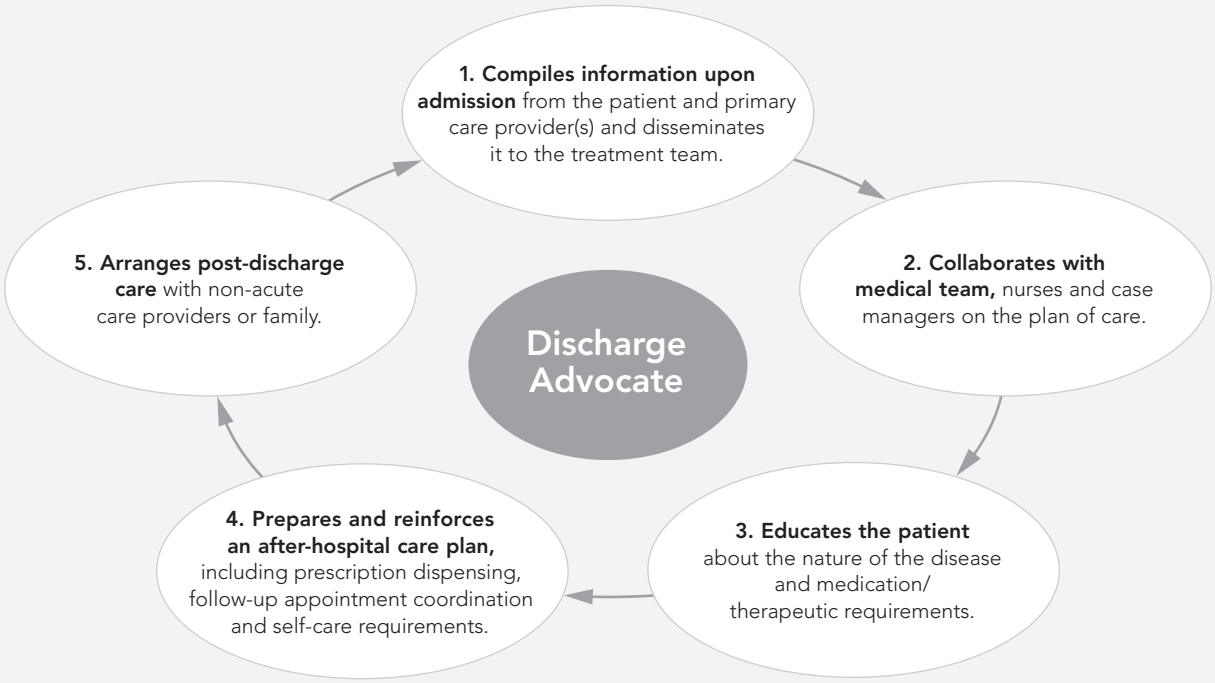
- Care Transitions Program®, furnishing tools for improving quality and safety during care handoffs.
- Institute for Healthcare Improvement, providing training on reducing preventable readmissions.
- National Transitions of Care Coalition, offering a range of bilingual tools and resources.
- Society of Hospital Medicine, sponsor of Project BOOST (Better Outcomes by Optimizing Safe Transitions).

In addition to enhancing coordination and communication, discharge advocates reduce the risk of premature discharge and consequent readmission by identifying the presence of acute health conditions that require ongoing intervention and monitoring. Finally, discharge advocates also should assess and document in the patient healthcare information record key functional and environmental factors influencing the patient's readiness for discharge, such as the following:

- Cognitive status and general capacity for self-care.
- Health literacy level.
- Current activity level and functional status.
- Cleanliness and suitability of the home environment.
- Support from family and/or significant others.
- Ability to obtain medications and services.
- Availability of transportation between home and hospital or clinics.
- Access to essential community services.

For more about the role and responsibilities of discharge advocates, see Project RED's "Discharge Advocate Training Manual".

Figure 2 – Core Responsibilities of Discharge Advocates



4. Implement after-hospital care plans.

Simple, brief and clearly written after-hospital care plans enhance communication with patients and can decrease the likelihood of medical setbacks and avoidable readmissions. Such plans should focus on critical information and tasks, including the following:

- **The patient's medical condition(s)** and primary diagnosis.
- **Symptoms that may arise,** as well as self-care information and instructions about how to respond if a condition deteriorates.
- **Discharge medications,** including a list of drugs to maintain or discontinue, as well as instructions regarding where to obtain them and when and how to take them. (For a sample medication reconciliation form for use in preparing discharge medication plans, see pages 6-7.)
- **Pending laboratory and/or diagnostic tests,** including laboratory contact information and instructions on how to retrieve results.
- **A calendar of follow-up appointments** and post-discharge testing dates and times.
- **Information on diet and exercise,** as well as durable medical equipment needs and operating instructions.
- **Contact information** for the discharge advocate, primary care providers, therapists and emergency care personnel.

A sample after-hospital care plan form and planning checklist are available here and here.

For patients who are discharged to their home, instructional aids and handouts should be tailored to the patient's level of literacy and health awareness. Educational materials should reinforce essential care directives, such as how to obtain and administer medications, perform self-care activities and comply with after-care appointments.

Discharge instructions, both written and spoken, should be included in the patient healthcare information record, as well as a description of the patient's/caregiver's level of comprehension. The National Patient Safety Foundation's "Ask Me 3" documentation format permits discharge planners and providers to judge patients' degree of understanding of post-discharge expectations, based upon their responses to the following three basic questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

5. Facilitate post-discharge communication.

Primary care providers require access to hospital discharge summaries during initial post-treatment visits. When summaries are not sent in a timely manner, the lapse creates a potential gap in continuity of care. By utilizing an electronic template for discharge summaries, staff can more consistently capture relevant information and ensure prompt delivery to designated recipients.

The discharge summary template should incorporate the following essential components, among others:

- **Indication of the reason for the hospitalization,** as well as the status of the primary diagnosis.
- **A list of procedures performed,** as well as related care and services provided.
- **Significant findings,** including the most recent laboratory results and operative reports.
- **Input from consultative services,** including rehabilitative therapy.
- **List of chronic conditions** considered in the discharge planning process.
- **A reconciled medication list,** including known drug allergies.
- **Identification of acute medical issues** and pending test results that require follow-up.
- **Description of the patient's condition at discharge,** reflecting significant issues and concerns.

Post-discharge telephone calls are another effective method of reducing return visits and improving patient follow-up. Telephone or message contact may be initiated by a discharge advocate, nurse, clinical pharmacist or the patient's primary care provider. The use of standard scripts can help callers monitor patient compliance with established parameters of care in an efficient and consistent manner. Telephone discussions with patients should focus primarily on their condition and mood, follow-up care needed and provided, and indicators for additional services (e.g., rehabilitation, home health assistance, hospice).

An effective hospital discharge plan can help minimize unnecessary readmissions and emergency room visits for patients with chronic health conditions or self-care challenges. The strategies outlined here can reinforce the planning process, coordination among providers and patient compliance, thus enhancing safety and quality, and reducing potential liability and reimbursement risks.

Sample Medication Reconciliation Form

Accurate medication reconciliation is critical to a successful discharge transition, helping ensure that patients understand what medications they have been prescribed, why they are taking them, and how and when to take them. The following format, which can be adapted to suit specific organizational needs, is designed to facilitate comparison of past and present medication regimes, thus revealing discrepancies and minimizing the possibility of drug interactions and other preventable post-discharge problems.

Patient name:	Healthcare record number:
Date of birth:	Date of hospitalization:
Pending discharge date:	Today's date:

Allergies (including medications, foods and other substances) – If none, check here ☐
If allergies exist, list below:

Allergen	Reaction
1.	
2.	
3.	

Drugs listed on pre-hospitalization medication administration record (including over-the-counter products, nutritional supplements and herbal remedies)

Name	Strength	Dosage	Frequency	Route	Last dose taken
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Current medications prescribed (including over-the-counter products, nutritional supplements and herbal remedies)

Name	Strength	Dosage	Frequency	Route	Validation – i.e., dated signature of prescribing physician/provider (yes/no)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

New medications

Name	Reason for use	Monitoring parameters and stop date
1.		
2.		
3.		
4.		
5.		

Previous medications omitted from discharge orders

Name	Last dose taken	Primary physician/provider notified (yes/no)
1.		
2.		
3.		
4.		
5.		

Prepared by:

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