Best Practices in Hospital Discharge to Reduce Preventable Readmissions

PATRICIA DONOVAN: This is Patricia Donovan for the Healthcare Intelligence Network. Today I am speaking with Michelle Berry, the Director of the Community Alterative Systems Agency or CASA in Broome County New York. Michelle is presenting at HIN's audio conference on "Best Practices in Hospital Discharge to Reduce Preventable Readmissions." Thanks for joining me today Michelle.

MICHELLE BERRY: Great. Thank you.

PATRICIA DONOVAN: To begin with many health care providers say that discharge planning should begin on the day the patient is admitted. From your organizations perspective is this a useful strategy?

MICHELLE BERRY: Well particularly with the short stays anymore in hospitals it is a useful strategy except that we think that it needs to be triaged in a way that when you approach someone in the hospital it really needs to be based on what their admission was for. If people come in for planned surgery often times in our community we know that they're going to say, they come in for a hip replacement or a knee replacement and they know that ahead of time they're often going to go to a short-term stay in a nursing home. But if someone comes in with a stroke or something that was not anticipated then I think the approach has to be different. It's nice to get in and speak to the family and find out what the situation was at home without maybe necessarily bringing up the fact that we're going to start working on your going home when they're just had this crisis in

Copyright 2007, The Healthcare Intelligence Network

their life. So I think it’s something that needs to be managed in a way that’s unique to each person that’s admitted.

PATRICIA DONOVAN: I see, thanks Michelle. Who should own the discharge plan and how should updates to discharge instructions be handled and communicated to the patient, and anyone who is involved in the discharge?

MICHELLE BERRY: Well you really want to make the patient feel like they own the plan although often times because of the situation they’re in they might not share that same view. We do find to I think as we move toward the idea that the patient does own their medical record our hospitals still tend to really be very protective of that information. So I think we have to start engaging the public more in a discussion of this is your information, a variety of providers probably need some of the information anyway in order to ensure that in each setting you’re in and the transition period is because people go from nursing home from hospital to nursing home to home care. And with the level of chronicity we’re all dealing with these days they go back and forth between these settings numerous times. And I think we really need to find a way to share that information that is patient centered and where the client understands that the information will be shared because they should really own it.

PATRICIA DONOVAN: I see. If I could just follow up on that, Michelle. At the moment I can see what you’re saying and I think with the trend of consumer driven health care we’ll probably get there, but for the moment with your organization, where does that information reside. Especially if you do have patients, as you said, going transitioning back and forth, who

is the central or where is the central repository for that information?

MICHELLE BERRY: Well that's the problem. There probably isn't a central repository and I think that's something as a community and as different communities across the nation we need to build toward that. We'd love to see a central repository for information that we could share. Right now I think the hospital feels like they own the information. And I think a good key in having the patient involved in the information, in the discharge plan itself, is to find somebody in the family who would be the pivotal person that you would be talking to all the time. Because then we get into a situation where you have people in and out and then you've got three shifts in the hospital and often times it's hard to transmit this information to the patient or the family. So I think the ownership question is kind of up in the air.

PATRICIA DONOVAN: I see, we'll have to watch that, watch what happens with that. I read about CASA's in home long-term care assessment. Could you describe that a little bit for us and the impact that it has on hospital and nursing home readmissions among the population that you serve?

MICHELLE BERRY: Yes. We have in our organization we operate the Medicaid Personal Care program for our county as well as some other Medicaid home care programs such as Private Duty Nursing. And when somebody goes into the hospital we also have nurses from our agency that assist the discharge planners and we have nurses from our agency that also work in our nursing home. So really CASA has a bird's eye view of every type of setting here in our community and we're probably the only agency in the

community that goes into all those settings consistently. And our home care assessment is social, emotional, environmental, physical. We're looking at everything when we go into the home. And one of my hospital discharge planners had a good comment the other day. She said, when she goes into the hospital and for instance might look at someone's record, their lab reports, right away when they go in the hospital it might indicate high blood sugars if they're diabetic. By the time they leave the hospital they probably have that under control. But to her that tells her something. That tells her right away that these people weren't maintaining this or controlling this well at home. And that's the kind of information we want to pass on. If a person goes to a nursing home for further rehabilitation they still might be well maintained with their blood sugars. But we don't want to forget the fact that when they came into the hospital there was something going on in the home so we would continue to move that information down the line. And we go into people's homes and do a thorough assessment, and we're looking at more than just the medical. The problem again being, we do have a sense that we help people stay out of the hospital but again with communication being what it is if we don't see a patient for 6-months and they end up going to the emergency room we might not know that. Again the need for some kind of a shared information system where if they did show up in the emergency room the emergency room could find out from the shared information system that this person is a home care client, and recipient, and has the ability to call someone to perhaps take care of the situation so they don't have to be admitted. I just see a lot of need for continuing to organize around information systems.

Copyright 2007, The Healthcare Intelligence Network

PATRICIA DONOVAN: Well we've seen a trend with the emergency room of having case managers and so on there to kind of raise a flag when something like that happens. So perhaps that's something that will evolve.

MICHELLE BERRY: Right. And we have, we hope to do an initiative in the coming year with some particular groups from physician offices and caregivers where we're going to try to hire someone to help the patient at home, develop what we call a guest list almost so that when the different providers come into their home they would sign in and sign out. Because someone might have a personal care worker, they might have a physical therapist, they might have a Certified Home Health Agency (CHA) nurse and they don't really know where everybody comes from or what to tell the doctor. And then when they go into the hospital sometimes the agencies get changed because the patient says I have a nurse, I know I have a nurse but I don't know where she comes from. So we're hoping to develop a program where the professional will go into the home, help the people maintain these records and this will be a hardcopy record, but we hope we can use it as a model that if we move into a internet based system that we can show providers that people do own this information. They're willing to share it this way and that we can move on to the next step of actually putting it online. But we're hoping that we can get a group of people that will take this notebook around with them to the doctors, to the hospital so that people can see the activity that goes on in the home.

PATRICIA DONOVAN: Do you have any prototypes for this notebook or forms or anything like that?

Copyright 2007, The Healthcare Intelligence Network

MICHELLE BERRY: We have some prototypes. There are caregiver notebooks out there that you can look at as models. But what we're hoping is to put the extra effort in there of actually having someone, not just hand the book out and saying, "Here do this. Fill this in." We really want to have someone do the training. Why you should do this, how you should do this, why it's useful, and to stick with them and see if we can generate some excitement in the community for it. If we can get people to start doing it and doctors find it to be useful and the hospitals find it to be useful we're hoping that we can generate just some excitement that people will start to use it. And we want to make it as simple as possible, simple or as complex as people want. Say for instance someone might have Parkinson's disease. Maybe they might want that information in the notebook. But the next person would want something on CHF. So if they want to build it around that or if they just want to keep it as a guest book. Today the CASA nurse was here, Friday the long term nurse was here and just as simple or as complex as they want but some kind of record that will follow them through each of their transitions.

PATRICIA DONOVAN: And so the person that you designate would be training the patient on using this?

MICHELLE BERRY: Yes.

PATRICIA DONOVAN: Okay. Well perhaps we can touch base with you in a few months to find out the status of that and get some more details.

MICHELLE BERRY: That would be terrific.

PATRICIA DONOVAN: But for now those are all the questions I have today Michelle. I want to thank you for being with us and we're looking forward to hearing more from you during the audio conference.