



Welcome: October 29, 2009

# Discharge Planning Decision Support:

A research study

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# Agenda

- Introductions
- Purpose of the study
  - Background and Significance
- History of the tool development
  - Purpose of the tools
- Outcomes of interest
- Potential work flow implications
- Next steps



# Study Leaders

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# Background and Significance

- Eliminating just 5.2% of preventable Medicare readmissions could save an estimated \$5 billion annually
- Within 30 days of discharge,
  - 19% of Medicare beneficiaries are re-hospitalized,
  - Estimate: up to 76% of these readmissions may be preventable
- Of the Medicare beneficiaries readmitted within 30 days,
  - 64% received no post acute care between discharge and readmission.
- Suggested interventions to prevent these re-admissions
  - identify high risk patients before discharge
  - devise new approaches to follow-up



# Purpose of the study

To demonstrate that patient outcomes improve when decision support tools are introduced into discharge planning practice for elderly patients.

# History & Purpose of the tools

Discharge planning involves critical decisions at two time points:

- 1) whether a patient needs a comprehensive evaluation by a discharge planner to identify their present needs and anticipate continuing care needs.

## **The Early Screen for Discharge Planning (ESDP)**

- 2) whether or not to refer the patient to post acute care services such as home care

## **The Discharge Decision Support System (D<sup>2</sup>S<sup>2</sup>)**

# ESDP components

- Four item screen completed upon admission includes an assessment of:
  - > Age
  - > Walking limitation
  - > Living alone
  - > Disability
- Cut off score determines those who the discharge planner should target for comprehensive assessment

# D<sup>2</sup>S<sup>2</sup> Components

- Six item screen completed on day 3:
  - > Age
  - > Walking limitation
  - > Self rated health
  - > Caregiver availability
  - > Number of co-morbid conditions
  - > Depression
- Cut off score determines those who the discharge planner should consider for post acute referral

# Study design

- Cluster randomized clinical trial
- Randomized by hospital or unit
- Four groups
  - Usual care
  - ESDP alone
  - D<sup>2</sup>S<sup>2</sup> alone
  - ESDP and D<sup>2</sup>S<sup>2</sup> combined

# Outcomes of interest

- Rates of referral to post acute services
- Quality of care coordination by 7 days
- Readmissions by 30 and 60 days
- Emergency department use by 30 and 60 days
- Quality of life by 7 and 60 days



# Implications for work flow depends on your environment

- How to consent patients
- Who will administer the tools
  - Research assistant
- How to deliver the decision support scores to the discharge planner
- Accessing chart information
- Accessing readmission and ED use information

## Frequently asked questions

- What will it cost my organization in money or staff time?
  - Staff time will be needed to attend orientation to using the tools
  - Staff time to make assessments and post acute referrals if they increase
- Any charges for access to data or on site study coordination
  - will be reimbursed by the study budget

## Frequently asked questions?

- Who will train the staff on using the tools?
  - The research team
- How long will the study run?
  - Depends on enrollment rate
- When will it start?
  - Either Dec 2010 or April 2011
- Do I need to involve home health agencies?
  - Let them know referrals may increase

# Frequently asked questions?

- What type of data will be collected?
  - Patient sociodemographic, clinical, and administrative (readmission, ED use)
- How will the data be collected?
  - Patient interview
  - Via chart review
  - Pulled from administrative databases
  - eDischarge reports

## Frequently asked questions?

- Will an application to the IRB be required?
  - Yes, we will be doing this at Penn and Mayo Clinic
  - If needed, we will submit to your IRB
- Will I be able to use the tools after the study?
  - Yes, once the data collection for the study is complete
  - We plan to provide a guide for translating this work into practice

# What's in it for my organization?

- Standardize and improve the discharge planning process
- Improve 30-60 day readmission and ED use rates
- Potential reimbursement protection if CMS pays differently for 'readmission rates'
- Recognition for participating in research

# Take home messages

- The quality of hospital discharge planning decisions determines
  - whether older adults living in the community receive the health and social services they need,
  - or are sent home with unmet needs and without services, leading to increased risk of readmission or developing costly, poor outcomes.
- The lack of time and resources available to hospital discharge planners calls for improved methods
  - to efficiently and accurately identify patients in need of post acute care
- WE BELIEVE THIS STUDY WILL ADDRESS THESE ISSUES

# Next Steps & Thank you

- Please email your interest to Kathy Bowles
- Please indicate “Research Study” in the subject line...
  - Thanks for that.
- We will continue dialogue and planning

[bowles@nursing.upenn.edu](mailto:bowles@nursing.upenn.edu)

Thank you.



## References

- Holland DE, Harris MR, Leibson CL, Pankratz VS, Krichbaum KE. Development and validation of a screen for specialized discharge planning services. *Nurs.Res.* 2006 Jan-Feb;55(1):62-71.
- Bowles KH, Ratcliffe SJ, Holmes JH, Liberatore M, Nydick R, Naylor MD. Post-acute referral decisions made by multidisciplinary experts compared to hospital clinicians and the patients' 12-week outcomes. *Med.Care* 2008 Feb;46(2):158-166.
- Bowles KH, Holmes JH, Ratcliffe SJ, Liberatore M, Nydick R, Naylor MD. Factors identified by experts to support decision making for post acute referral. *Nurs.Res.* 2009 Mar-Apr;58(2):115-122.