

Effective Comprehensive Discharge Planning for Hospitalized Elderly

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Article:

People age 65 and older comprise 11% of the U.S. population, yet at any given time, they occupy 40% of acute care hospital beds (National Center for Health Statistics, 1985). The majority of this elderly population has Medicare coverage. Anderson and Steinberg (1984) reported that between 1974 and 1977, 22% of Medicare hospitalizations were followed by readmissions within 60 days of discharge. More than 5% of these readmissions occurred within 5 days of discharge.

Throughout the last decade there have been a number of different approaches by health care professionals to improve the outcome of hospitalization for elderly patients. In one of the earliest studies, Schragger et al. (1978) examined the effect of physician and nurse referral to a social worker within 2 days of admission. When the lengths of stay were compared, the patients referred were discharged an average of 5 days sooner than patients without referrals. Cable and Mayers (1983) subsequently considered the effect of discharge planning on the length of stay in three community hospitals. With the onset of a discharge planning program, the length of stay increased for some patients.

The interdisciplinary team approach to care of the hospitalized elderly has also been examined by Campion et al (1983). In their experimental study, the effects of a Geriatric Consultation Team (GCT) in a large teaching hospital were determined. Forty-six consecutive patients age 75 and older received consultations from the GCT. A higher percentage of patients in the treatment unit required placement in nursing homes than was true for the 86 patients in two control units, Within 1 month of discharge the readmission rate for the treatment unit was 43%, and for the two control units, 36% and 42%. Another approach to discharge planning had one nurse who had functioned as a liaison between a hospital and visiting nurses association identify patients who would benefit from early discharge planning (Inui et al., 1981). The nurse concluded that of 279 patients studied, 9.6% required special placements.

Method

Within the study institution, the Utilization Review Plan indicated that discharge planning was individualized depending on each patient's post-hospital needs. Assessment and planning for patient post-hospitalization needs was the responsibility of the primary nurse, with assistance of other members of the health care team. Documentation of family support and teaching and referral needs were entered in the progress notes of the patient's chart. To better predict the degree of intervention required, a comprehensive discharge planning protocol (CDPP) was developed for use by the Gerontological Clinical Nurse Specialist (GCNS). It was based upon Orem's Self Care Model (1980) and Falcone's work (1979). Components of the assessment portion included: health status, orientation level, knowledge and perception of health status, resource use pattern, functional status, skill level, motivation level, and sociodemographic data, The patient's level of dependency was measured using the Long-Term Care Information System (LTCIS). Following the protocol, the GCNS met with the patient, family, physician, and other health care providers to identify resources and support networks for the patient post-discharge. A summary of the assessment information and potential care needs were entered in the progress notes of the patient's chart. Once the plan of care was identified, the GCNS assisted in the coordination

of services required by the patient. Emphasis was placed upon communication with the patient and family to explain and clarify discharge plans. An additional follow-up visit was made to assess the continuing appropriateness of the planned placement disposition. This protocol was followed for all patients entered into the treatment group.

Table 1. Demographic Profile (n = 80)

Description	Treatment (n = 39)		Control (n = 41)	
	n	%	n	%
Ethnicity				
White	35	(90)	40	(98)
Black	4	(10)	0	(—)
Hispanic	0	(—)	1	(2)
Religion				
Protestant	29	(74)	35	(85)
Catholic	2	(5)	1	(2)
Other	8	(21)	5	(12)
Gender				
male	20	(51)	18	(44)
female	19	(49)	23	(56)
Marital Status				
married	22	(56)	25	(61)
widowed	17	(44)	12	(29)
divorced			2	(5)
single			2	(5)
Residence				
within county	25	(64)	25	(61)
Age				
range	75 – 93		75 – 94	
mean	80.05		80.53	
median	79		79	

The purpose of this double blind experimental design study was to determine if the CDPD implemented by the GCNS would result in improved patient care for hospitalized elders. Improved patient care, or effectiveness, was measured on the basis of the following outcome criteria: (1) decreased length of stay in the acute care setting; (2) non-readmission to the acute care facility within an 8-week time period following the first discharge; and (3) appropriate discharge placement reflected by no change in original placement, or change to a less dependent level of care, if indicated. It was hypothesized that elderly patients involved in comprehensive discharge planning by the GCNS would be more likely to experience positive outcomes.

Sample. —The study was conducted in a 500-bed, non-profit, acute care teaching hospital in Central Texas. The first 80 elderly patients admitted to non-intensive care units expected to stay at least 72 hours and, giving written permission to participate, were entered into the study between September 16 and October 14, 1984. All were 75 years of age or older, English-speaking, and could be reached by telephone after discharge.

Indicated by the sociodemographic data was that the two groups were similar, as shown in Table 1. The baseline functional status scores obtained at the time of the initial interviews most frequently revealed dependency in four activities of daily living for both groups. Translated, this indicated the need for supervision and housekeeping according to the LTCIS service needs criteria. The majority of patients lived with their family or significant others: Only one patient in the treatment group lived farther than 50 miles from his family. Three patients in the treatment group were nursing home residents who returned to that setting after hospital discharge. One patient in each group died during hospitalization. Six more patients died (2 from the treatment group and 4 from the control group) within weeks of discharge.

Instruments. — Three instruments were used in the study: the LTCIS (Falcone, 1979), a Telephone Survey Guide, and a Chart Audit. All were deemed to have face validity. The LTCIS was initiated by Jones (1974) and further developed by Falcone (1979) in response to problems associated with selecting appropriate long-term care for the elderly. Consisting of two parts, the first part elicited general information, including a person's health and functional status. The person's functional status score could range from zero to seven and reflected

the number of dependent activities of daily living (ADLs). In part two of the LTCIS translated are service needs using 20 assessment items to systematically project whether any of the 11 identified services are needed. Services include audiology, dental, emotional and social assessment or treatment, home finding, housekeeping, meal preparation, nursing, ophthalmology, physical therapy, speech therapy, and shopping. Prior to the initiation of the study, the GCNS received formalized training in the use of the LTCIS. Falcone (1979) reported 90% and higher reproducibility for all types of general assessment information included in the tool. In this study, consistency was maintained by limiting the use of the protocol to one clinical nurse specialist.

The Telephone Survey Guide was developed to assist in gathering data regarding patient outcomes at 2 and 4 weeks post-discharge. Questions regarding the patients' present placement, resources utilized, changes in the original plan, and assessment of the patients' perceived needs for relocation or transfer from their present placement were included. The Chart Audit Guide aided in retrieving data from hospital records (principal and secondary diagnoses, discharge date, and number and dates of readmissions).

Procedure.—The research assistant identified potential study participants from the hospital's admission summary sheet and then, in consultation with nursing staff, determined if individuals met the study's criteria. The assistant recorded baseline sociodemographic data from the patient, significant others, and medical records on a pre-coded data sheet. The functional status of all patients was assessed and recorded on the Functional Status form of the LTCIS.

Using a computer-generated randomization program, each patient had a 50% probability of being placed either in the treatment or control group by the Biostatistics Department. Patients assigned to the treatment group were seen by the GCNS who carried out the CDP. The CDP complemented the ongoing care delivered by the primary nurse and other care providers.

Two and 4 weeks after discharge from the hospital, all study patients or their primary caregivers were contacted by the research assistant. The Telephone Survey and LTCIS Functional Assessment were used to determine current placement and functional ability. At 8 weeks post-discharge, the Chart Audit was completed on all 80 patient charts. Data management and analysis were conducted by the Biostatistics Department of the hospital, using Statistical Analysis System (SAS), software developed for the microcomputer, and custom written programs.

Results

A difference of almost 2 days in the length of stay (LOS) was found to exist between the groups. Treatment group patients were hospitalized for an average of 7.8 days, whereas the patients in the control group remained in the acute care setting 9.7 days. This difference of 1.9 days in the average LOS was statistically significant ($p < 0.05$).

For the 78 participants discharged from the hospital, the recidivism rate over 8 weeks for the treatment group was 29% (10 patients, 11 readmissions) and for the control group 35% (12 patients, 14 readmissions). The patients in the control group averaged 10.8 days before returning to the hospital following discharge, whereas those in the treatment group averaged 22 days. This difference was primarily due to 8 readmissions in the control group occurring within 7 days of discharge, whereas only 2 in the treatment group were readmitted. Five of the readmissions in the treatment group occurred between 21 and 56 days after discharge, whereas only 2 of the control group occurred in the same time span.

The change in placement disposition was assessed 2 and 4 weeks after discharge from the hospital. Data revealed that for at least 87% of surviving patients in both groups, no change in placement occurred from the time of discharge to the first telephone interview 2 weeks later. Information gathered during the 4-week interview again revealed that the majority of patients in both groups had remained at their original placements.

Discussion

The findings generated from this study supported the need for comprehensive assessment and planning for the hospitalized elderly (Pfeiffer et al., 1981; Rubenstein, 1983; Williams, 1983). The 2-day reduction in hospital stay for patients in the treatment group is consistent with the work of Schragger et al. (1978) and suggested by the reduction is that the implementation of an early discharge planning protocol can facilitate discharges to other settings when appropriate. In comparison to the study in which a geriatric consultation team (GCT) assessed hospitalized elderly (Campion et al., 1983), the average lengths of stay of their treatment group was 11.2, 3.4 days more than in the current study. It may be that time needed for coordination among multidisciplinary team members increased the patient's LOS. Also, the incentive to facilitate discharge planning has changed since the other study was conducted. The shorter lengths of stay may be indicative of the impact of prospective reimbursement and the stimulus for hospitals to reduce the length of hospitalization as suggested by Weinburg et al. (1984).

The recidivism rate reported for this study reflected those patients who returned to the study hospital within an 8-week time period or to other acute care facilities within 4 weeks of discharge. Although the readmission rates for both groups were similar, a higher percentage of patients in the control group returned to the hospital sooner than the patients in the treatment group. This finding is similar to the study reported by Campion et al. (1983), where little difference in number of total readmissions was found to exist. The ability to plan for care needs and to help the elderly remain out of the hospital for longer periods of time is becoming increasingly important with the DRG prospective payment mechanisms.

The high percentage of all patients reporting no change in placement disposition at 2 and 4 weeks was comparable to other studies in which outcomes of hospitalization of elderly patients were examined (Munoz & Mesich, 1979; Robertson & Rockwood, 1982). The majority of patients had identifiable support systems that provided the supervisory and housekeeping functions necessary for the patient to remain in the original placement environment. Three patients in this study (4%) were admitted from nursing homes and returned to them after discharge.

Conducted in one institution, the study was influenced by internal patient care practices. Although early discharge planning was implemented during the first few days of hospitalization, 3 patients in the treatment group were not assessed because they were discharged within 2 to 4 days of admission. In a small number of treatment group cases in which plans for aftercare management were identified, the recommendations were not implemented due to conflicting opinions of the family or medical staff. As compared to an earlier study (Cable & Mayers, 1983), this institution has a skilled nursing unit and a home care agency which eases the process of discharge planning for all patients admitted to the institution.

Discharge planning, fundamental to effective health care delivery, involves a complex assessment of patient needs and the integration of hospital and community patient and support services. This integration process establishes a crucial link between the patient and community that facilitates reentry into the community (Donnelly, 1979). By having a GCNS coordinate discharge plans for hospitalized elderly, patients and families have available to them a resource person with the knowledge of the patient's prescribed medications, treatments, diet, and activity limitations who can also design a plan of care for post-hospitalization. By working in collaboration with physicians, nurses, and other members of the health care team, the GCNS recommendations for discharge planning may include community resources and placements, adaptive and safety equipment in the home, and provisions for maintaining patient well-being after hospitalization. Giving the patient and family the opportunity to participate in these plans enhances the discharge planning, process and promotes the patient's sense of self-responsibility.

The study needs to be replicated with other populations and in other settings to determine if differences found in this study hold true. For now, it is to the institution's advantage to use the most appropriate resources available to facilitate a patient's discharge when acute care services are no longer needed.

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