



HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

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AHC Media

To prevent readmissions, think outside the hospital walls

Partnerships with post-acute providers are a must

The stakes are rising in the quest to base hospital reimbursement on quality.

Initiatives from the Centers for Medicare & Medicaid Services (CMS) and commercial insurers mean that case managers no longer can create a discharge plan that ends when patients leave the hospital. Instead, they must look beyond the hospital walls and work closely with post-acute providers to ensure that the discharge

plan will succeed.

“New initiatives mandated by the Affordable Care Act make it imperative for hospitals to coordinate care throughout the continuum and avoid penalties. Hospitals need to develop strong relationships with their post-acute providers and work together to improve care and ensure smooth transitions,” says **Marcia Colone**, PhD, ACM, LCSW, system director for care coordination at UCLA Health with headquarters in Los

EXECUTIVE SUMMARY

Initiatives from the Centers for Medicare & Medicaid Services (CMS) and commercial payers that penalize hospitals when patients are readmitted make it necessary for providers throughout the continuum to collaborate and ensure that patients get the care they need.

- Create discharge plans that go beyond the hospital walls and coordinate with the post-acute providers to ensure that they have the information they need to help the patient follow the plan.
- Develop close relationships with post-acute providers by meeting with them face to face and discussing ways to improve transitions and solve problems.
- Track quality metrics, such as readmission rates, and share them with the providers. When patterns occur, alert the group to work on solutions.

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EDITORIAL QUESTIONS

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Angeles. UCLA Health's readmission prevention programs include leasing beds at skilled nursing facilities to ensure that hard-to-place patients have a bed, and partnering with home health agencies to increase the number of contacts patients receive.

In a way, hospitals are being penalized twice for Medicare readmissions within 30 days of discharge — once in the readmission reduction program, where they can lose up to 3% of their Medicare reimbursement, and again in the Medicare Value-based Purchasing Program, since stays for patients who are readmitted to the hospital typically cost more than the initial hospital stay.

Commercial payers are also developing readmission reduction programs, according to **Karen Zander, RN, MS, CMAC, FAAN**, president and co-owner of the Center for Case Management.

When hospitals participate in accountable care organizations or bundled payment programs, they also bear risk for what happens to patients after discharge, Zander says.

"Hospitals have to get to know the post-acute providers in their network, whether they own them or not, and be willing to partner with them to discuss critical issues and to share information," Zander says.

The problem hospitals face with all of CMS' quality initiatives is that the healthcare infrastructure was built for volume and not value, points out **Brian Pisarsky, RN, MHA, ACM**, associate director at Berkeley Research Group, with headquarters in Emeryville, CA.

"We have to make a fundamental change in the day-to-day work of case managers. It's no longer just utilization review and discharge planning. Care across the continuum is what needs to happen and it takes

a different approach from what we've done in the past," he says.

Information that clinicians at the next level of care need often falls through the cracks when patients transition, says **Toni Cesta, RN, PhD, FAAN**, partner and consultant in New York-based Case Management Concepts.

"There's only so much the hospital side can do. Hospitals have to improve communication during handoffs to post-acute providers to ensure that patients get the care they need in order to avoid readmissions," she said.

"Unfortunately, some hospitals have said that they can't control what goes on after a patient is discharged. This may well be true, but all the providers throughout the continuum are engaged in care of very sick people and to do this, you need collaboration between the various settings," Cesta says.

Case managers need to shift their strategies and develop a detailed discharge plan that can be accomplished outside the four walls of the hospital, says **Mindy Owen, RN, CRRN, CCM**, principal owner of Phoenix Healthcare Associates, a Coral Springs, FL, consulting firm, and senior consultant for the Center for Case Management.

Care plans no longer can be implemented and completed in the hospital setting, Owen points out. "That is why it's critical to have collaboration and communication across the entire continuum of care," Owen says.

Care plans for joint replacement patients are a prime example, she adds.

"The length of stay for joint replacement patients has shortened so drastically that hospitals no longer have the ability to provide intensive rehabilitation in the inpatient setting.

Therefore, the transitional plan of care must include rehabilitation in order to avoid a readmission when the patient experiences complications or is not able to perform some of the activities of daily living,” Owen says.

At the same time, now that hospitalists treat many of the patients in the hospital, outpatient clinics and primary physician practices often don’t have the detailed information they need to help their patients transition from the hospital to the community, she says.

“One of the biggest problems with transitions is that nobody follows up on the results of tests patients have before they leave the hospital. The primary care physicians don’t know that the patients have had the tests and orders them again,” Cesta says.

Hospital case managers have got to improve their communication with their counterparts at post-acute providers, including primary care physician practices, she adds.

As hospitals have begun to participate in accountable care organizations and bundled payment agreements, they have started to develop relationships with local skilled nursing facilities and home health agencies, but few have built a comprehensive program that truly looks at patients along the entire continuum of care, Pisarsky says.

“We can no longer feel we’ve done our job if we provide excellent care between the four walls of the hospital but ignore what happens to patients when they leave. The solution is to build comprehensive care coordination and collaboration across the entire continuum, but there are obstacles to overcome,” he adds. One of the biggest obstacles is lack of access to medical records across the continuum, says.

“Now each individual entity has a different piece of the record. The

problem is that the hospital uses a different system from the skilled nursing facility, and the pharmacy and the home health agency have other systems and none of them interact with each other. This has to change,” he says.

In order to take a comprehensive approach to readmissions, hospitals have to collaborate and communicate with all of the providers along the healthcare continuum in the community, Pisarsky says. This

THE PROBLEM HOSPITALS FACE WITH ALL OF CMS’ QUALITY INITIATIVES IS THAT THE HEALTHCARE INFRASTRUCTURE WAS BUILT FOR VOLUME AND NOT VALUE.

includes primary care providers, skilled nursing facilities, long-term acute care hospitals, rehabilitation facilities, home health agencies, Area Agencies on the Aging, and anyone else who may participate in the healthcare of patients.

The best way to forge a good relationship is for hospital staff to meet once a month with the post-acute providers in their area to share data and brainstorm on solutions to problems, Zander adds.

“It’s harder to know somebody on the other end of the phone than if you see them in person. It’s better to work on building relationships along the way rather than trying to establish a relationship when you need someone’s help,” Zander says.

Post-acute providers that are a part of the hospital system are a natural place to start collaborating across the continuum, Owen says. Also involve providers that are not part of the health system, starting with the ones to which you transfer the most patients, Owen suggests.

It’s helpful to cement relationships with providers who will give your patients quality care, Zander says, but be careful not to alienate other providers, she says.

While some hospitals try to work with any post-acute provider that will take their patients, other hospitals are trying to develop narrow networks of preferred providers and collaborate with a few carefully chosen providers, Zander says. However, Medicare patients still must have a choice of providers and if they choose providers who are not in the network, the hospital has no choice but to discharge them to that provider, she adds.

One way to narrow the field is to give preference to those who use the INTERACT (Interventions to Reduce Acute Care Transfers), a quality improvement set of activities designed to help facilities reduce potentially avoidable transfers by early identification and assessment of changes in patient conditions, Zander suggests.

Look at the CMS Home Health Compare (<https://www.medicare.gov/homehealthcompare>) and Nursing Home Compare (<https://www.medicare.gov/nursinghomecompare/search.html>) websites for information on post-acute providers. “CMS doesn’t tell you everything, but the information on those websites along with data hospitals have compiled will help identify providers who provide quality care,” she says.

Every hospital should convene

a monthly meeting of community-based providers, advises **Amy Boutwell**, MD, MPP, president of Lexington, MA-based Collaborative Healthcare Strategies, and one of the original co-developers of The Institute for Healthcare Improvement's STAAR (State Action on Avoidable Rehospitalizations) initiative.

She suggests that the meeting include representatives from home health agencies, skilled nursing facilities, hospice providers, physicians, representatives from federally qualified health centers, elder service agencies, behavioral health clinics, and the larger community health clinics.

"It sounds like a big undertaking but it's in the best interests of post-acute providers to collaborate with hospitals. This does not need to be a first step to developing a network. It's simply a meeting where all the parties can discuss how to work better together," she says.

Some hospitals have invited 80 or more providers to the meeting. Set up a regular time and date for the monthly meeting and issue an open invitation, Boutwell suggests.

"People who come to the meeting consistently will demonstrate their

commitment to improving patient transitions and will show the hospital that they are the best partners," Boutwell says.

Zander recommends that the hospital's director of case management chair the meetings and keep them running smoothly and bring up topics and data for discussion.

Develop a to-do list and keep working on it, she advises.

Owen tells of working with a hospital that brought together representatives from skilled nursing facilities and home health agencies to look at problems that were causing readmissions.

"The first problem they identified was medication reconciliation. The issue was that the forms the hospital used were different from the forms used by the other providers and the electronic communication tools did not sync. This resulted in medication errors that sent patients back to the emergency department. Once all the providers started using the same communication tool, we saw a huge drop in readmissions," she says.

Colone advises other hospitals to invest in relationships with post-acute providers over the long term, and share quality metrics with them.

Develop a process to address issues such as referral denials and readmissions and constantly review the referral process and handoffs, she says.

When you see a pattern of problems, work with the group to develop a strategy. Keep the conversation about topics of concern general and don't single out individual providers, Zander advises.

Share your statistics on readmission rates with the post-acute providers but meet with each individual provider to discuss the data, Zander says. "It's important to keep each provider's data separate and confidential from the other providers. You don't want to embarrass them," she says.

When patients are readmitted, in addition to finding out the discharge destination listed in the medical record, find out where the patients were when their conditions brought them back to the hospital, Zander says. "There are so many steps along the way that it's sometimes hard to know exactly where patients came back from. Case managers should interview patients and families and drill down to find out where the patient was before being readmitted," she says. ■

IMPACT Act levels the playing field on healthcare performance

Post-acute providers required to report data

A Congressional act requiring post-acute providers to track and submit data gives hospitals a great opportunity to develop close working relationships with post-acute providers, says **Wanda Pell**, MHA, BSN, a director with Novia Strategies, a national healthcare consulting firm.

The Improving Medicare Post-Acute Care Transformation Act (IMPACT), passed in the fall of 2014, requires home health agencies, skilled nursing facilities, long-term acute care hospitals, and inpatient rehabilitation facilities to submit standardized data, including

quality measures, resource use, and other measures.

"This is an opportunity for hospitals to work more closely with skilled nursing facilities and other post-acute providers and communicate better, improve transitions, and as a result, experience

fewer readmissions,” Pell says.

The Act is intended to help spur the trend of more integrated care throughout the continuum, says **Kurt Hopfensperger**, MD, JD, senior medical director of audit, compliance, and education at Executive Health Resources, a Newtown Square, PA, healthcare consulting firm.

“This is part of the Centers for Medicare & Medicaid Services’ [CMS]’ push for overall quality as it moves from voluntary reporting of quality measures to mandatory reporting to basing reimbursement on the data reported. It is part of the move from fee for services to fee for value and quality,” he says.

The IMPACT Act standardizes data collection and data sharing, Hopfensperger says. “The idea behind IMPACT is that standardizing data improves transitions of care and results in better care and more affordable care,” he adds.

Dates for implementation vary among the types of providers and the different domains. The earliest that providers will be required to report data is Oct. 1, 2016. CMS will make the performance data public beginning in 2018.

IMPACT requires providers to collect standardized data in the

following domains: skin integrity and changes in skin integrity; functional status, cognitive function, and changes in function and cognitive function; medication reconciliation; incidence of major falls; transfer of health information and care preferences when a patient transitions; resource used measures, including that total estimated Medicare spending per beneficiary; discharge to the community; and all-condition, risk-adjusted potentially preventable hospital readmission rates, according to **Elizabeth Hogue**, Esq, a Washington, DC-based attorney specializing in healthcare issues.

Through the IMPACT Act, CMS will require collaboration between levels of care as well as effective discharge planning, enhanced transition services, and support for caregivers at home, Hogue says.

In the first phase, CMS is requiring the post-acute providers to collect standardized data, Pell says. After analyzing the data, CMS will report back to Congress. CMS will require some types of providers to report data in some domains as early as Oct. 1, 2016, phasing in the others over a three-year period. Providers that do not report data will receive a reduction in reimbursement.

CMS will develop a mechanism for public reporting of performance data beginning in 2018.

“This Act will put hospitals and all post-acute providers on a level playing field by giving them the same incentives,” Pell says.

In requiring post-acute providers and facilities to collect data, CMS is trying to get a consistent approach across the board, Pell says. “CMS is going to pick and choose data points and compare them all. This is just a preview of coming attractions. CMS says it wants to develop a uniform payment system, regardless of the site of services. This is the next wave and it seems likely that the end result will be some kind of bundled payment system,” she says.

IMPACT gives hospitals a great opportunity to work on improving readmissions from post-acute providers, Pell says. “Hospitals that have relationships with skilled nursing facilities and meet regularly with them tend to have lower readmissions rates. The same is true about hospitals that collaborate with home health agencies and rehabilitation facilities,” she says.

The requirements of the Act give post-acute providers an incentive to work on initiatives to help avoid hospital readmissions, Hogue says.

“Savvy facilities are already collaborating with hospital case managers and discharge planners. When they understand that they will be monitored, they’ll get on board. This Act should make them realize that the day is not too far off when they’ll be in the same situation as hospitals and will face penalties for readmission,” Hogue says.

So far, there are no penalties for readmissions from post-acute providers but this is likely to be forthcoming, Hogue says. “Soon, both sides will have skin in the

EXECUTIVE SUMMARY

The Improving Medicare Post-Acute Care Transformation Act (IMPACT), which requires post-acute providers to compile and submit quality, performance, and resource use data, gives hospitals an opportunity to work closely with the providers to which they discharge patients.

- The Act standardizes data collection and data sharing among post-acute providers. The data will eventually be reported publicly.
- The IMPACT Act is part of the CMS emphasis on basing reimbursement on quality. Currently, post-acute providers are paid on a fee-for-service basis.
- The Act gives post-acute providers an incentive to work on initiatives to reduce readmissions to collaborate with hospitals on improving transitions.

game,” she says.

Case managers should be building collaborative relations with post-acute providers, Hogue says.

“We now are calling on discharge planners and case managers to do a whole lot more to improve transitions, including developing collaborative relationships with post-acute providers. It’s no easy task and it will take some time for the resources to catch up with what is now required,” Hogue says.

Hogue suggests that case managers

study the interpretive guidelines in the Medicare Conditions of Participation to help them develop relationships with post-acute providers and develop effective discharge plans. “The interpretive guidelines include suggestions about effective discharge planning and lay out in detail what case managers and discharge planners are supposed to be doing. Not only do they specify what is required in great detail, but they also include suggestions,” Hogue says.

Case managers have to give

patients a choice when it comes to post-acute providers, but when the IMPACT Act is fully implemented, they will have another way to assist patients in choosing, Pell points out. “Eventually, patients will be able to look at quality measures for home health agencies and skilled nursing facilities so they’ll have more than just a subjective way to choose. This ties into the entire trend you see now for hospitals and other providers becoming patient-centered,” she says.



Bed leasing program helps hospitals discharge hard-to-place patients

Nurse practitioners placed in SNFs help cut readmissions

By paying skilled nursing facilities a negotiated daily rate to hold beds for its hard-to-place patients, UCLA Health saved a total of 2,516 acute care days between June 2014 and July 2015 by placing patients in the leased beds.

“The program is paying for itself, even with all the costs of the bed lease. Without our arrangement with the skilled nursing facilities, we would be keeping these patients

in the hospital longer,” says **Marcia Colone**, PhD, ACM, LCSW, system director for care coordination at UCLA Health, with headquarters in Los Angeles.

UCLA Health includes two acute care hospitals: Ronald Reagan UCLA Health, a 520-bed Level 1 trauma center located in Los Angeles, and Santa Monica UCLA Health with 266 beds. The system also includes Resnick Neuropsychiatric Hospital

and Mattel Children’s Hospital.

The hospitals experience 45,000 emergency department visits and 25,000 admissions each year and consistently have an occupancy rate of 95% or higher.

“We are an academic medical center and many of our patients have very high acuity and complex conditions, along with psychosocial issues that create barriers to discharge. Many are homeless, have no insurance, or are underfunded. When these patients need to go to a skilled nursing facility, it is difficult to place them,” Colone says.

The goals for the program include reducing emergency department wait times, reducing length of stay for hard-to-place patients, and cutting readmissions and emergency room visits among patients discharged to skilled nursing facilities, she says.

UCLA Health also developed a strategic partnership with home health providers and formed the Enhanced Home Health Quality Council to share information on

EXECUTIVE SUMMARY

UCLA Health’s program that pays a negotiated daily rate to skilled nursing facilities to hold beds for patients who otherwise would stay in an acute care bed saved a total of 2,516 acute care days from June 2014 to July 2015.

- UCLA Health pays a negotiated daily rate if the beds are occupied or not. The rate covers boarding, nursing care, medications, and physical therapy and occupational therapy
- Nurse practitioners are embedded in the participating nursing homes and provide care for UCLA Health’s patients every day, often treating problems that might cause a readmission.
- The program helps with emergency department throughput and frees up acute care beds for patients who need them.

CASE MANAGEMENT

INSIDER

CASE MANAGER TO CASE MANAGER

Interdisciplinary Walking Rounds: A Key Strategy for Improving Case Management Outcomes – Part 1

By Toni Cesta, PhD, RN, FAAN

Introduction

This month we are going to focus on interdisciplinary rounds — more specifically, walking or bedside rounds. Bedside rounds have fallen in and out of favor over the years, but more recently have become increasingly popular. Recognized as a tool for improving efficiency and communication, they have been endorsed by the Institute for Healthcare Improvement (www.ihl.org) and The Joint Commission (www.jointcommission.org). They are also an effective and efficient tool for hospital case managers to use to gather information on their patients and to hear the plans of the other members of the interdisciplinary care team.

BEDSIDE ROUNDS HAVE FALLEN IN AND OUT OF FAVOR OVER THE YEARS, BUT MORE RECENTLY HAVE BECOME INCREASINGLY POPULAR.

radiologists, lab technicians, and pharmacists. There are a lot of individuals and departments that require constant input and information-sharing with case managers. So, how do case managers keep all these communication channels synchronized and organized?

Part of the solution includes handoff communication. Handoffs occur when a patient is transferred from one caregiver to another for a day or for the remainder of an episode of care. Case managers hand off their patients to social workers, other case managers, next level of care providers, nursing unit managers, and others. The Joint Commission's Patient Safety Goal Number 2 emphasizes the need to improve effective communication among caregivers. It speaks to the need for effective communication to be in the form of

written as well as verbal communication and recommends five expectations for effective handoffs:

1. Interactive communication allowing for the opportunity for questioning between the givers and receivers of patient information.
2. Up-to-date information regarding the patient's care, treatment and services, condition, and any recent or anticipated changes.
3. A process for verification of the received information, including repeat-back or read-back, as appropriate.
4. An opportunity for the receiver of the handoff information to review relevant patient historical data, which may include previous care, treatment, and services.
5. Interruptions during handoffs are limited to minimize the possibility that information would fail to be

Teams and Communication

In order for teams to be the most effective, they must have hard-wired communication processes in place. These formal processes for communication are enhanced with informal means of communication that happen throughout the day between and among caregivers. Additionally, case managers must consider all the methods by which they communicate. For example, case managers conduct elements of vertical communication which might include communication with the case management department leader, the physician advisor, or case management extender.

Case managers also participate in horizontal communication on a routine basis, including communication with nurses, physicians, hospitalists,

conveyed or would be forgotten.

How do these five strategies apply to case management? They tell us that as case managers we must be sure to have interactions that are communicative as we hand off patients, not just written notes or reminders. These interactions should be comprehensive and include details as outlined in numbers 2 and 4 above. We should have a process to ensure that the person receiving our information understands it, and finally, we should be sure to conduct the handoff in a location where we can be sure to have minimal interruptions.

There are a variety of tools for effective handoffs. Below is a list that includes the department primarily responsible for the process.

- Change of shift rounds: Dept. of Nursing
- Teaching rounds: Dept. of Medicine
- Patient care conferences: Interdisciplinary
- Huddles: Interdisciplinary
- Internal patient transfers: Interdisciplinary
- Walking rounds: Interdisciplinary

Patient Care Conferences

Patient care conferences are used as an adjunct to walking rounds and are planned when more detailed information needs to be conveyed than can be done in the walking rounds format. These rounds may also include family members. Consider patient care conferences when the specific patient case is complex or involves legal, ethical, or other similar issues.

Huddles

Huddles are a shortened version of patient care rounds. They are typically conducted in the afternoon as a follow-up to the rounds done in the morning. Huddles can be scheduled or impromptu, but are typically scheduled. If the huddle is a routine meeting that is a follow-up to morning walking rounds, then it is usually attended by a staff RN, case manager, and physician.

Internal Patient Transfers

When patients move from one unit to the other or from the emergency department to an inpatient unit, there should be written summaries and verbal exchanges of information between case managers and/or social workers. This is one area in which case managers often fall short.

Why Walking Rounds

Walking rounds, or bedside rounds, enable all members of the healthcare team who are caring for a specific patient to offer their individual expertise and make informed contributions to the care of that patient. During walking rounds, all the various disciplines are able to come together to better coordinate the patient's care. Walking rounds also improve communication among and between the team members.

The IHI and The Joint Commission both consider walking rounds as best practice. According to the Center for Patient Safety, standardizing work is one of the best ways to reduce errors (www.centerforpatientsafety.org).

In addition, walking rounds are a critical element of patient flow. They are a tool for identifying delays in patient care processes as they are happening and take action to correct

them using the resources of the entire care team. Walking rounds are not change of shift report. They are an interdisciplinary care planning tool where expected outcomes of care, barriers to care, care transitions, and discharge information can be shared among the team members.

The Focus for Rounds

There are a number of elements to focus on for walking rounds. During rounds, each of these elements should be focused on as part of the "talking points." We will discuss more on the talking points later. The elements listed below can be used to support your hospital's rounds talking points.

- **Coordination of care:** This component is key to the walking rounds process. Coordination of care should begin with a review of the patient's current status with input from each team member. This should be followed by a discussion and clarification of the patient's goals and expected outcomes of care. Finally, a comprehensive plan of care should be developed or modified as appropriate.

- **Communication:** Rounds is the best time to discuss any issues associated with patient safety, patient education, and daily goals. By communicating together as a team, the group can be better assured that a consistent approach will be used by all the team members.

Key Components to Consider When Developing Rounds

The following steps, while not necessarily linear, are essential elements for the development of the rounding process.

- 1. Identify and refine your goals for rounds.** The rounds development team should determine what the

purpose is for rounding in your organization and reach consensus from the group as to what the goals of rounding will be. The goals should be consistent throughout the organization regardless of the unit or specialty service.

2. Create a structure and stick to it. The rounds development team should define the structure for rounds prior to implementation. This structure should be consistent throughout the organization so that whatever unit is rounding should have a similar process.

3. Identify the leader of rounds. The leader should be identified by discipline or job title. This might be a physician, hospitalist, nurse manager or case manager, for example. Whenever possible, the leader should be consistent regardless of unit or specialty. A back-up to the leader should also be identified.

4. Pick a standard time for rounds each day. A time should be selected that is mandatory and applied consistently on every unit. The only exception to this might be the critical care units.

5. Engage with the patient and the family. A mechanism for including the patient and family in rounds should also be established. This might include discussions with them at the bedside, and additional patient care conferences as needed.

6. Measure success. Before beginning your organization-wide rounds, have the rounds development team identify the ways in which you might measure the success of your rounding process. Collect pre-implementation data before you begin.

Who Should Attend Rounds?

There is a minimum list of

disciplines that should be attending rounds, and others can be added as needed. With the patient at the center, recommended team members should include the staff nurse caring for the patient, the hospitalist or physician of record, and the case manager. Additional disciplines can be added as needed. Additional team members will be dependent on the specialty of the nursing unit. For example, if the unit specializes in orthopedics, then it would be recommended that a physical therapist be included in rounds. On a geriatric unit, a nutritionist might be a good addition. At a minimum, be sure that the team members selected represent all relevant disciplines. Some may need to be added on an ad hoc basis as well.

Strategies for Getting Started

A good first step is to leverage your existing rounds processes. It is possible that some of your nursing units already conduct some form of a rounding process. This may be in a conference room or bedside. Conduct an assessment of the current rounds on the units that have them and compile a spreadsheet outlining the similarities and differences between them. Some of the existing rounds may already be in the format that the rounds planning committee has established and will need little to no revision or change. Others may be totally off the mark and need complete revision to their existing processes.

The next step would be to seek out one or two nursing units that are willing to participate. Willing participants increase the likelihood that you will be successful with the first units that are implemented. Start small by implementing on one or

two units first. In this way, you can identify any issues that may need to be adjusted or corrected and make those corrections before you go any further.

Start by educating the team members as to the goals of the rounds and the processes. Segment the processes so that team members can gradually embrace the elements of the rounding process.

The rounds planning team should develop a daily documentation tool that can be placed in the electronic medical record and be used to document the attendees of rounds and the outcomes. Each patient should have a daily goal documented and agreed on by the interdisciplinary team. Track interventions and patient outcomes against these goals on rounds each day and get feedback from each team member caring for the patient.

Scheduling the rounds by nursing beds is a good way to frame the structure. Identify the beds assigned to each staff nurse and cohort the beds accordingly. If you need to round with a specialty physician, then focus on those patients with that physician.

Scripting

Scripting, or developing “talking points” for the team, can increase the likelihood that the rounds will be kept to the key elements and not take too long. Standardize the key questions that the team wants to answer as well as the questions that the team wants to address with the patient and family. Write them on the goal sheet or some other tool. Use the scripting as a means of keeping the discussion of each patient to sixty seconds on the average. Remind the team to keep academic discussion related to anatomy and

pathophysiology, medications, or similar issues out of the patient's room unless the patient specifically asks to be included in these discussions.

Part of the scripting should include what will be said to the patient as well as how to manage the patient and family's expectations. Be sure to include something about addressing patient questions that may require more time. Let the patient know that someone will come back after the rounds are completed to address their questions. Also plan to have support staff trained to bring the patients water, tissues, or other such items if they ask for them during rounds.

Format for Scripting

Item #1: Diagnostic one-liner. A diagnostic one-liner should include the age, sex, relevant history related to the current problem, and the current chief complaint or reason for hospitalization. This is a good way to begin the rounding discussion.

Item #2: Demographics. The patient's demographics should be included in the scripting. Demographics should include the following:

- Name
- Gender
- Admission date
- Expected length of stay
- Primary physician
- Insurance information
- Relevant family information or other support systems
- Other

Item #3: Problem list. The problem list should cover any pertinent medical history. Pertinent medical history refers to medical or surgical problems or events that may have relevance to the current hospitalization. You may want to

use a systems-based list of current medical problems. Include a discussion of any invasive tubes or devices currently in use. Included in this should be Foley catheters, drains, or other such similar devices.

Item #4: Expected tasks to be completed or ordered. Expected tasks to be completed might include laboratory or radiology tests that have yet to be

PART OF THE SCRIPTING SHOULD INCLUDE WHAT WILL BE SAID TO THE PATIENT AS WELL AS HOW TO MANAGE THE PATIENT AND FAMILY'S EXPECTATIONS.

done or other diagnostics not yet completed. Delays such as these can have a negative impact on cost, quality of care, and length of stay and should always be included in a rounds discussion.

Additionally, any tests needed to be ordered should also be discussed. This is the time to identify any gaps in care and address them with the team. The physician can then follow up with an order if that is what is lacking.

Item #5: If/Then. Frequent issues to be expected that will need a plan to resolve can be discussed in an if/then format. For example, "If patient is hypertensive, then give hydralazine". This format can

be used to reinforce any practice guidelines that you may have by standardizing the intervention associated with a specific diagnostic finding or physical assessment.

Item #6: Therapeutics. The discussion should also include a review of therapeutics or treatments the patient is currently receiving, such as the following:

- Medications
- IV meds — focus on when they can be switched to oral
- Diet with any weaning orders
- Oxygen with any weaning instructions

Item #7: Results and other important facts related to:

- Labs
- Cultures
- Radiology test results
- Consultations

Item #8: Care coordination. The case manager should interject with the patient's expected length of stay, plus any patient care barriers of a social or insurance nature that might impede the patient's ability to be discharged.

Summary

This month, we began our discussion of walking rounds with an overview of why rounds are important and how you might begin to structure rounds in your organization. Because IHI and TJC both identify walking rounds as best practice, we have focused our discussion on the elements needed for a successful walking rounds process.

Next month, we will continue our discussion of walking rounds with strategies for preparing for rounds, as well as how to engage the patient and family in the rounding process. ■

improving services to patients, Colone says. (For details, see related article below.)

Patients who were placed in skilled nursing facilities through the bed reservation program had an average of 9.6% all-cause 30-day readmission rate from the second quarter of 2013 through the first quarter of 2014, she says. This compares with an average of 30.9% among other patients at UCLA Ronald Reagan and 24% at UCLA Santa Monica.

The program placed 91 patients through the bed reservation program in 2012 and 261 patients in 2014, a 60% increase.

The program started in 2011 at two skilled nursing facilities and five reserved beds. The health system has expanded to 25 leased beds at the two facilities. The daily rate includes boarding, nursing care, medications, and physical therapy and occupational therapy, Colone says.

“If nobody is in the bed, we pay

the daily rate and they hold it for our use. If we place a paying patient in the bed, we avoid paying the daily rate for the time they are in the facility,” she says.

The arrangement does not mean that the skilled nursing facility will accept any patient referred to them. The patient has to meet the facility’s criteria, Colone says.

Case managers on the unit identify patients who are potential candidates for the bed reservation program on a daily basis and begin working on a discharge plan early in the stay, she says.

A key to the success of the program is two nurse practitioners, who are employees of the health system and work full-time at the facilities to care for the patients who are transferred from UCLA Health, Colone says.

The nurse practitioners see patients every day, write orders, and treat them for issues that might cause a readmission.

The physicians at the skilled

nursing facility are not required to see the patients every day, Colone points out. “Because they see the patients infrequently, they don’t see small problems that can get worse and lead to a readmission. The nurse practitioners see patients every day and take steps to prevent readmissions,” she says.

By being able to place patients without funding in a skilled nursing facility, UCLA Health frees up a bed for patients who require an acute bed. The program also improves patient flow and throughput by reducing the time patients spend in the emergency department waiting for a bed, Colone says.

The program is an advantageous situation for the skilled nursing facilities, too, Colone adds.

“The skilled nursing facilities know that to become a partner with UCLA is very important in terms of marketing and branding. By affiliating with UCLA, the facilities improve their chance of getting more paying patients,” she says. ■

Partnership increases contact between patients, home health nurses

Hospital, agencies work to standardize referrals, share information

UCLA Health has formed a partnership with three home health agencies that agreed to increase the number of times home health nurses interact with patients after they are discharged from the hospital to home with home health services.

The agencies agreed to provide a minimum of seven “touch points” or contacts with patients during the first two weeks after discharge.

The home health nurses either visit the patients while they are still in the hospital or introduce themselves with

a telephone call before the patient is discharged.

They make two to three home visits the first week, including a visit within 24 to 48 hours of discharge and a home visit the first weekend the patient is at home.

The home health agencies agreed to provide two to three home visits the second week, including a home visit the second weekend the patient is at home. They make “tuck in” telephone visits on the first and second Fridays to check on

the patient.

“The touchpoints have tremendous benefits for the patients. In addition, the program has greatly improved our relationship with participating home health agencies,” says **Marcia Colone**, PhD, ACM, LCSW, system director for care coordination at UCLA Health in Los Angeles.

The health system’s first analysis of patients seen by the home health agencies showed no significant difference in readmissions or emergency department visits between

the enhanced home health services and standard services, Colone says. However, a second analysis showed that patients who were part of the enhanced home health program were less likely to be readmitted to the hospital than patient who received regular home health services, she adds.

As part of its initiatives to reduce readmissions, UCLA Health created the Enhanced Home Health Quality Council, a partnership between the

health system and the home health agencies. The goals of the council are to improve communication between UCLA Health facilities and external providers, to create an infrastructure to allow accountability, and to standardize referral processes as patients move from the inpatient to the outpatient setting.

The council meets regularly to share information and solve problems, Colone says. Among the accomplishments so far are

standardizing the discharge process and the discharge information the providers receive, creating an infrastructure to allow accountability, and standardizing the referral process between the inpatient and outpatient settings.

“The home health agencies were very eager to participate in the program and were willing to add additional phone calls and visits to their routine services at no cost to UCLA or the patient,” she says. ■

Video handoffs cut readmissions from post-acute providers

Nurses use tablet technology to communicate

The readmission rate for patients being discharged from Oregon Health & Science University Hospital to a skilled nursing facility have dropped from 26% to 12% among patients whose handoffs were handled via videoconferencing.

Using secure, HIPAA-compliant videoconferencing, the hospital nurse goes to the patient’s bedside and connects with the nurse who will be caring for the patient at the receiving facility.

The health system started doing video handoffs in 2012 with one skilled nursing facility that was willing to invest in the needed technology and agreed to partner with Oregon Health as part of a larger package to improve the quality of care. So far, the inpatient team has conducted more than 300 video handoffs and now is working with five skilled nursing facilities and Oregon’s only long-term acute care hospital with three more sites scheduled to participate, says **Nancy Trumbo**, MN, RN, NE-BC, director of care management for

Oregon Health & Science University Hospital, located in Portland.

The 534-bed hospital is the only academic medical center in Oregon and 60% of its patients come from outside a 50-mile radius of Portland.

“Before we started this initiative, we had implemented programs to reduce readmissions for patients who are transitioning from the hospital to home. As the health system became more accountable for ensuring that our patients continue to progress once they leave the hospital, we knew we had to partner differently with the post-acute providers,” Trumbo says.

The care management team already had a partnership with skilled nursing facilities and the long-term acute care hospital to collaborate on the quality of care and looked at ways to reduce those readmissions from those facilities, Trumbo says.

“When we researched the literature and conducted a root cause analysis, we found that readmissions for patients from a skilled nursing

facility seem to be for a different reason than readmissions for patients who were discharged to home,” Trumbo says.

The team drilled down on readmissions from skilled nursing facilities and determined that patient anxiety within the first 24 hours was one of the major drivers of readmissions.

“Patients weren’t necessarily coming back because of a decline in medical status. They were coming back because they were dissatisfied with the skilled nursing facility, or that their pain was not controlled. We sensed that the root cause of many readmissions was anxiety related,” she says.

The care management team began looking at ways to make patients feel more comfortable about the facility where they were going, Trumbo says.

Oregon Health & Science University already had a robust telemedicine program it rolled out in 2007 to provide support for clinicians treating pediatric patients in outlying hospitals. The

telemedicine network has been expanded to hospitals and outpatient clinics across Oregon and provides diagnostic and treatment advice on a wide range of diagnoses, says **Jean McCormick**, RN, MSN, clinical nurse educator for telehealth services.

“We are always talking about different ways to use telehealth services. Teleconferencing offers a creative way of making handoff reports. It enhances the process because nurses at the receiving facility don’t get a full picture of the patient when the hospital nurse just talks to them,” McCormick says.

The care management team and the telemedicine team collaborated on the development of the program and continue to work closely, Trumbo says.

“There is no way we could do the work we do without a partnership with telemedicine,” she adds.

When patients are ready for discharge, the case manager contacts the receiving facility and arranges for the videoconference between the hospital nurse and the nurse at the receiving facility. The goal is to have the videoconference 15 minutes before the patient leaves the hospital, McCormick says.

A case management assistant connects with the receiving facility

and hands the tablet to the nurse. “We did not want technology to be a barrier that made the bedside nurses reluctant to conduct a handoff report over a tablet at the bedside instead of the telephone, so we have our administrative coordinator take care of the technological details,” Trumbo says.

The program has grown so much that the care management department no longer has enough personnel to handle setting up the video conferences for the nurses on the 16 units. The unit secretaries are being trained to make the video connection, Trumbo says.

In the past, the nurses made the handoff call from their desks. Now that they’re in the patient rooms, the nurse at the receiving facility can see the patient and any equipment being used, McCormick says. “Patients have an opportunity to speak about their care and most of them do. It makes them feel like they are a part of the plan,” she says.

Being a part of the videoconference helps allay the anxiety patients may have about going to a new facility where they don’t know anyone, Trumbo says.

“Often, patients are apprehensive about going to a skilled nursing facility but they have been delighted to be involved in the video handoff.

They get to meet the nurse who will care for them in the new facility and this makes them feel much more comfortable about going. They know they will see a friendly face when they get there,” Trumbo says.

Some staff were reluctant to try the technology at first, Trumbo says. “It’s easy for the younger nurses who are accustomed to an online presence, but some of the other nurses are less comfortable with the technology but they see the benefits,” she says.

The unit nurses appreciate the ability to have face-to-face conversations with the nurse who will care for the patients and have begun to develop relationships with them. The skilled nursing facility nurses like being able to see the patients and start the relationships, she says.

Once the facilities invest in the teleconferencing technology, they can connect with anyone on the network, Trumbo says. For instance, when the LTACH discharges patients to a skilled nursing facility, the staff conducts a warm video handoff.

The next phase is to develop the ability for the nurses and physicians in the hospital emergency room to examine skilled nursing facility patients via teleconferencing when the nursing home staff is concerned about their conditions, potentially avoiding an emergency department visit or a hospital admission.

“Now that CMS has begun a readmission reduction program for skilled nursing facilities, they are willing to pay the hospital for a remote physician visit. It can avoid a readmission, decrease our emergency department utilization, as well as decreasing adverse effects on patients. It’s a way for us to make sure patients get the care they need at the bedside,” Trumbo says. ■

EXECUTIVE SUMMARY

When Oregon Health & Science University Hospital began video handoffs when patients were being discharged to a skilled nursing facility, readmission rates dropped.

- The hospital nurse goes to the bedside and connects with the nurse who will be caring for the patient at the receiving facility.
- The program makes patients feel more comfortable about the new facility and gives the nurse a chance to meet his or her patient.
- The hospital also conducts educational sessions via videoconferencing for the staff at the skilled nursing facilities.

Educational programs target gaps in knowledge at SNFs, LTACH

Hospital experts share tips via videoconferencing

When nurses at Oregon Health & Science University Hospital began using videoconferencing to hand off patients to nurses in a post-acute facility, the hospital team noticed that some of the nurses in the receiving facility often had gaps in knowledge.

“Some were not familiar with the equipment we were sending with the patient, or they didn’t know how to care for a patient with a central line. In addition to explaining it during the handoff report, we decided to create a series of educational sessions that we could deliver via videoconferencing for the staffs at all of the participating facilities at once,” says **Jean McCormick**, RN, MSN, clinical nurse educator for the Portland-based health system’s telehealth program.

McCormick made a list of the gaps in knowledge she had observed during the videoconferencing session and developed a series of monthly one-hour programs, starting with a four-part series on care of central lines.

The “brown bag” educational programs are held at lunch time on the third Thursday of each month. McCormick produces the programs and brings in hospital experts to discuss each topic and to demonstrate procedures or how to use equipment.

The staff at the facilities that participate in the teleconferencing handoffs watch the programs on a television. After the presentation, staff from all the facilities are invited to discuss how they deal with a particular situation or specialized task. “It facilitates a lot of discussions

and gives the nurses a chance to share ideas,” she says.

Program topics include how to perform a stroke assessment, basics about heart failure, use of ventricular assist devices, and wound and ostomy care. For the program one month each year, McCormick asks nurses from each site to submit three cases, walks through each one, and asks the nurses to discuss what they have learned. The December program includes highlights from every topic that has been discussed that year.

“This is a way the hospital can contribute to the knowledge base at the skilled nursing facilities and make sure our patients will receive high-quality care. At the same time, every patient in the facility will benefit from the education we provide,” she says. ■

Do your duty: Report all infections

Anecdotal reports suggest some trying to “game” the system

Two leading federal agencies are warning hospitals and other facilities that they can be fined and denied Medicare funds if they are caught intentionally underreporting healthcare-associated infections (HAIs).

As CMS pay-for-performance penalties and incentives target infection control, there are “anecdotal reports” of hospitals attempting to skirt the rules and not report all HAIs to the CDC. An Oct. 7 CDC-CMS joint statement reminds all facilities that

it is critical to report all HAIs to the CDC’s National Healthcare Safety Network (NHSN).

The gold standard surveillance system has expanded in recent years as CMS began linking infection rates to reimbursement. Many had predicted that pay-for-performance would inevitably lead to such a situation, as fiscally strapped hospitals may succumb to the temptation of underreporting. The strongly worded statement contained some warnings of consequences and allegations of

unethical behavior, but a CDC official interviewed for this story took a more conciliatory tack.

“This is about due diligence,” says **Michael Bell**, MD, a medical epidemiologist in the CDC’s Division of Healthcare Quality Promotion. “We don’t have a sense of how common this is — we don’t know that it is happening very much but because the data are now used for reimbursement, we just wanted to put out a reminder that there is an added level of responsibility in terms of

accuracy. You don't want to fall into a situation of misrepresenting information that is related to payment. A lot of people who have traditionally looked at these data from an infection control perspective maybe aren't thinking of it [that way]."

The joint statement said that the CDC "has received reports from NHSN users indicating that in some healthcare facilities, some of the decisions about what infections should be reported to NHSN are made by individuals who may choose to disregard CDC's protocol, definitions, and criteria or who are not thoroughly familiar with the NHSN specifications. While there is no evidence of a widespread problem, CDC and CMS take any deviation from NHSN protocols seriously."

In some cases, the decisions may be made through a review process that "overrules the decision of an infection preventionist or hospital epidemiologist" to report an infection to NHSN, the CDC and CMS reported. Other issues of concern are reports that some facilities are ordering diagnostic tests in the absence of clinical symptoms.

"It has been reported that in some instances, when patients are admitted to a hospital, diagnostic microbiology tests are ordered even in the absence of clinical indications for testing, such as obtaining urine specimens for culture and sensitivity testing from patients who have no symptoms of a urinary tract infection," the agencies stated. "Many negative culture results are generated by this practice subjecting the patient to potentially unnecessary tests. On the occasion that a culture result is positive, the results are

then used to assert that infections that first manifested themselves clinically many days later during hospitalization were present on admission and hence not reportable to NHSN."

Again, there were clear warnings by IPs and other clinicians that these types of strategies may be adopted as CMS began declining full reimbursement for certain hospital-acquired conditions that could be perceived as preventable. However, few probably anticipated the most serious allegation: reports that some facilities are "discouraging the ordering of diagnostic tests in the presence of clinical symptoms. It has been reported that in some instances clinicians responsible for inpatient care in some hospitals may be discouraged from ordering diagnostic microbiology tests recommended by best medical practices (or standards of care) to avoid test results that would make infections reportable to NHSN," the CDC and CMS reported.

Bell said he had no additional information on that allegation, but added that testing, in general, can be done inappropriately in an effort to secure reimbursement. The CDC's NHSN has validation systems and CMS does "spot checks" of facilities reporting data linked to reimbursement, Bell adds. In addition, CMS warned of serious consequences and called for

whistleblowers to call a tip line.

"CMS reminds hospitals that intentionally reporting incorrect data, or deliberately failing to report data that are required to be reported, may violate applicable Medicare laws and regulations," the joint statement read. "The Department of Health and Human Services' Office of Inspector General (OIG) protects the integrity of HHS programs, including Medicare and Medicaid. The Inspector General has the authority to exclude individuals and entities from participation in the Medicare, Medicaid, and other Federal healthcare programs and to impose Civil Monetary Penalties for certain misconduct related to Federal healthcare care programs. Hospital staff who become aware of intentional deviations from NHSN reporting protocols are encouraged to report their concerns to the OIG hotline."

OIG reporting can be done via any of the following:

Phone: 1 (800)-HHS-TIPS

1 (800)-447-8477

Fax: 1 (800)-223-8164

Email: HHSTips@oig.hhs.gov

For questions about the content of the notice, contact: CDC Division of Healthcare Quality Promotion Policy Office

Phone: (404) 639-4000

Email: DHQP_Policy@cdc.gov

COMING IN FUTURE MONTHS

- Improving communication and eliminating silos
- How shadowing patients can open your eyes
- Is the readmission reduction program unfair?
- Having that talk about end-of-life options

HOSPITAL CASE MANAGEMENT

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CNE QUESTIONS

- 1. According to Karen Zander, RN, MS, CMAC, FAAN, president and co-owner of the Center for Case Management, the best way to forge a relationship with post-acute providers is to meet with them monthly on a face-to-face basis.**
 - A. True
 - B. False
- 2. According to Mindy Owen, RN, CRRN, CCM, when a hospital client met with representatives from skilled nursing facilities and home health agencies, the first problem they identified that caused readmissions was medication reconciliation. What was the reason for the problem?**
 - A. Patients weren't giving providers complete information about their medication.
 - B. The receiving providers sometimes didn't have the medication the patient was taking in the hospital.
 - C. The hospital used different medication forms that the other providers used and the electronic communication tools did not sync.
 - D. All of the above.
- 3. UCLA's partnership with home health agencies calls for home health nurses to have a minimum of how many "touch points" with patients during the first two weeks following discharge?**
 - A. Seven
 - B. 10
 - C. 14
 - D. Two to three
- 4. When a team of care managers at Oregon Health & Science Hospital analyzed the reasons that patients were being readmitted from skilled nursing facilities, what did they find was a major driver of readmissions within the first 24 hours after discharge?**
 - A. Medication problems
 - B. Anxiety
 - C. Missing information in the discharge summary
 - D. All of the above

Hospital Case Management

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