HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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New discharge planning rules focus on preferences, transitions

Prepare now for new requirements from CMS later this year

Hospitals may have to make major changes in their discharge planning process if the Centers for Medicare & Medicaid Services (CMS) enacts a proposed rule beefing up the discharge planning requirements in the Medicare Conditions of Participation (CoPs).

Hospitals have to comply with the Conditions of Participation or they

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services has issued proposed changes to the Medicare Conditions of Participation that would increase the focus on patient preferences in the discharge process and beef up communication when patients are discharged from the hospital.

- The requirements would be in effect for critical access hospitals, long-term acute care hospitals, and inpatient rehabilitation hospitals in addition to acute care hospitals and would require a discharge plan for patients receiving observation services, patients being released from the emergency department, and patients receiving same-day surgery or procedures that require anesthesia or sedation.
- The proposed rule requires the discharge plan to include patients' goals and preferences and that the treating physician help create the plan. It includes specific requirements for discharge instructions.
- A big focus is providing the primary care physician with the discharge summary and other comprehensive information to the patient's primary care physician within 48 hours of discharge and pending test results within 24 hours of their availability. It spells out specific information that should be provided at the time a patient transfers to a post-acute facility or is referred for home health services.

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could be fined or lose their ability to bill for Medicare and Medicaid.

The proposed rule was issued Nov. 3, 2015, with the period for comments from stakeholders ending Jan. 3. According to **Sue Dill Calloway**, RN, MSN, JD, CPHRM, CCM, CCP, president of Patient Safety Education and Consulting in Dublin, OH, Mary Ellen Palowich, EMTALA technical lead and hospital analyst for CMS, predicts that the final rule will likely be published in February.

"The proposed rule reinforces what CMS has recommended in the past to improve the discharge process and reinforces the importance of case managers in a hospital," says **Jackie Birmingham**, RN, BSN, MS, CMAC, vice president emerita of clinical leadership for Curaspan, a Newton, MA-based consulting firm.

The rule expands the patient population included in the discharge planning requirements to include patients being discharged from critical access hospitals, long-term acute care hospitals, and inpatient rehabilitation hospitals. In addition, it requires that case managers or social workers create a discharge plan for patients receiving observation services, patients in the emergency department, and those receiving same-day surgery or procedures that require anesthesia or sedation.

The proposal includes similar discharge planning rules for critical access hospitals and proposed rules that home health agencies must follow when they discharge patients.

CMS rewrote the discharge planning standards in 2013 and in November 2014 published the discharge planning worksheet for state and federal surveyors to use when they assess hospitals' compliance with the Medicare CoPs, Dill Calloway says. Many of the requirements in the proposed rule were included as suggestions in the worksheet's advisory boxes, she adds. CMS will have to rewrite the discharge planning worksheet to reflect the changes when they are final, Dill Calloway says.

CMS mandated the changes to address some of the biggest gaps in readmission prevention and patient transitions, adds **Larry Magras**, MD, MBA, FACPE, senior director at Huron Consulting, a Chicago-based healthcare consulting firm.

CMS is definitely focusing on readmissions, including preventing readmissions by patients receiving observation services, emergency department patients, and outpatient surgery, he adds.

The proposed regulations were also written to implement the discharge planning requirements of the Improving Medicare Post-Acute Transformation Act of 2014 (IMPACT), which 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, Dill Calloway says. *(For details on the IMPACT Act, see the December 2015 issue of* Hospital Case Management.*)* Many of the requirements of the act are being addressed in separate rules, Dill Calloway says.

The proposed rule requires hospitals to develop a discharge planning process that includes patients' goals and preferences in the discharge plan, prepares patients and their caregivers to follow the patient's discharge plan, provides a smooth transition to post-acute care, and, in the process, reduces readmissions, Birmingham says. The proposal also calls for hospitals to

assess the discharge planning process on a regular basis and review the cases of patients who were readmitted within 30 days, looking for ways that discharge planning and patient transitions can be improved.

"The proposed regulations are solidifying what the more progressive institutions have already built: a robust discharge process for all patients and a focus on preventing readmissions," says **Donna Turtle**, FACHE, MPH, RN, director at Huron Consulting. Hospitals may have to make changes in how they provide discharge planning in order to comply with the proposed regulations, she adds.

She advises hospitals to review their discharge planning process in its entirety and ensure that what they are doing meets the needs of patients and includes all goods and services the patient will need after discharge.

Hospitals should revise their discharge policy to include the new requirements and make the entire staff aware of it, Dill Calloway says.

The proposed regulations require hospitals to get input from the medical and nursing staff, along with other relevant staff such as social workers and discharge planners, when they develop the discharge planning policy. The policy must be in writing and must be approved by the hospital board.

"Hospitals also may want to consider redrafting the discharge planning evaluation to include the CMS requirements," Dill Calloway says. *(For details on what the discharge evaluation must include, see box on page 22.)*

The rule requires hospitals to identify potential discharge needs for every patient within 24 hours of admission and complete the process before the patient is discharged or transferred to another facility. If a patient stays less than 24 hours, the discharge planner still must identify the patient's needs and complete the discharge planning process and not delay the discharge or transfer.

The regulations state that the discharge evaluation must be coordinated by a qualified person such as an RN or a social worker, Dill Calloway adds.

Hospital staff tend to think that responsibility for a discharge planning assessment belongs only to case management, but that's not true, Birmingham says. "Assessing for admission criteria and utilization review are also assessments," she says.

> "THE PROPOSED REGULATIONS ARE SOLIDIFYING WHAT THE MORE PROGRESSIVE INSTITUTIONS HAVE ALREADY BUILT: A ROBUST DISCHARGE PROCESS FOR ALL PATIENTS AND A FOCUS ON PREVENTING READMISSIONS."

Collaboration between case managers and the nursing staff is going to be critical in order to meet the requirement to perform a discharge planning assessment within 24 hours of admission, Birmingham says.

"Nursing typically has delegated anything to do with discharge planning to the case managers, yet staff nurses perform the admission assessment and find out more about the patients than anybody else. Hospitals need to ensure that discharge planning assessment is part of the job description for staff nurses," Birmingham says.

Under the new regulations, case managers no longer will be able to just develop a discharge plan and present it to patients, says **Kathy Jermain**, RN, BSHM, IQCI, director with Huron Consulting.

"Now, CMS is proposing that they involve the patient and the entire hospital team in the discharge planning process. A big focus is engaging the patient and family in actual discharge planning. The proposal requires discharge planners to consider the patient's and caregiver's ability to perform the care needed after discharge, and include the patient's goals and preferences in developing a discharge plan," Jermain says.

The rule also emphasizes that treating physicians should be involved in developing the discharge plan, rather than the more typical practice when the case manager creates the plan and the physician signs off on it, Birmingham says.

Dill Calloway suggests that a good way to comply with the rule is for an interdisciplinary committee to be involved in the discharge planning process, especially for a high-risk patient, such as one who just had a major stroke. The committee should include the attending physician, the rest of the clinical staff providing care, and the patient's support person, she says.

The new emphasis on transitions and preventing readmissions means that hospitals should perform an admission assessment and a discharge evaluation on every patient, Turtle says.

"We are at a point in healthcare now where the acuity of patients

being discharged from inpatient facilities has risen. We should assume that all patients are going to need discharge planning unless it's ruled out," Turtle says.

A good discharge plan should be a blend of the patient's clinical and psychosocial needs along with financial issues, Turtle says. "It works well for the case managers to lead the discharge planning and determine what skill sets are needed to complete the plan and then involve social work if the patient has psychosocial or financial needs," she says.

The rule also requires patients to be re-evaluated for discharge needs throughout the stay and that the plan be revised to reflect any changes in patients' conditions or needs, Dill Calloway says.

In recent years, a best practice has been for case managers to see every patient and complete a discharge evaluation plan, then review the record every day to see if there are changes, she says, recommending that all hospitals should adopt the practice.

"Most discharges aren't complicated, but case managers need to know what is happening with patients and adjust the discharge plan accordingly. If case managers don't see the patients every day, they have to rely on nurses for information on any changes and the nurses are busy doing their own jobs and may not inform the case managers of the changes," Dill Calloway adds.

For instance, a patient who has uncomplicated surgery could develop deep venous thrombosis and have an anticoagulant prescribed. The patient would need a consultation from a pharmacist and a dietician as well as follow-up visits to an anticoagulant clinic, she says. Or, a patient could fall and need a wheelchair after discharge. "If case managers don't monitor the changes, they could overlook a discharge need that would result in a readmission," she says.

The rule makes a clear distinction between patient education and discharge instructions, Birmingham points out. "The staff can do a great job on educating the patient about his disease, but they need to provide detailed, written discharge instructions," she says. For instance, tell a patient with diabetes, "'Call your doctor if your glucose level is above 100 or below 60,' and include the physician's contact information," she says. *(For details on what the discharge instructions should include, see box on page 22.)* ■

Preventing readmissions is a core focus of new discharge planning rules

CMs must look beyond the hospital stay when creating a plan

In the proposed changes of the discharge planning portion of the Medicare Conditions of Participation (CoPs), CMS reaffirms the goal of preventing hospital readmissions by ensuring safe transitions.

Among the requirements of the proposal are post-discharge follow-up by the hospital, ensuring that patients see a primary care provider after discharge and that the provider has detailed information on the hospital stay within 48 hours of discharge, assisting patients in choosing a post-acute provider that can meet their individual needs, and making sure that the receiving provider has all the information needed to help the patient recover and stay out of the hospital.

All hospitals — including critical access hospitals — must establish a process for post-discharge follow-up, points out **Jackie Birmingham**, RN, BSN, MS, CMAC, vice president emerita of clinical leadership for Curaspan, a Newton, MA-based consulting firm. This requirement will be a cost burden for many hospitals, she adds.

"When case managers call patients after discharge, they will have to ask standard questions and if something is wrong, they have to take some kind of action. For case managers with a caseload of 30 patients, the phone calls may take longer than the discharge plan," she adds.

Case management directors and hospital leaders should think carefully about the best way to meet the criteria, Birmingham says. "There's not a perfect solution. It will be impossible for hospitals to call everybody without some technology unless they add significant staff," she adds.

Follow-up may be an extension or enhancement of what is currently in place at many hospitals, says **Donna Turtle**, FACHE, MPH, RN, director at Huron Consulting, a Chicago-based healthcare consulting firm. Many hospitals are already calling

at least some of their patients within 48 hours after discharge to ascertain if they are having problems, if they understand their discharge instructions, or are having difficulty getting any of the post-discharge services they need, she adds.

One challenge for case managers is going to be arranging a post-discharge follow-up appointment for patients who are admitted through the emergency department and have no primary care physician, says **Larry Magras,** MD, MBA, FACPE, senior director at Huron Consulting. "When patients are not connected to a primary care physician, follow-up becomes more labor intensive," he says.

"The biggest challenge for case managers will probably be the requirement to have the discharge summary and discharge instructions in the hands of the primary care provider within 48 hours," says **Sue Dill Calloway**, RN, MSN, JD, CPHRM, CCM, CCP, president of Patient Safety Education and Consulting in Dublin, OH. When patients are ready to be discharged, case managers need to make sure the attending physician dictates the discharge summary into the medical records, Dill Calloway says. "Getting this done may be challenging for case managers," she says.

About a third of patients go home with test results pending and many times the primary care physicians don't even know about the tests, Dill Calloway points out. The proposed rules require hospitals to make sure that pending test results are sent to the primary care provider within 24 hours after they are available, she adds.

The discharge instructions form should have a box that indicates pending tests, Dill Calloway says. When additional tests are ordered by the treating physician, she recommends that the tests be scheduled before the patient is discharged.

"If you just write in the discharge instructions that the physician wants another test and don't schedule it and nobody makes sure the test is performed, it may get lost in the system," she says.

When patients are referred for post-acute services, the proposed rule mandates that hospitals assist the patients and their families in choosing a provider, Birmingham says. Patients will still have the freedom to choose their facility, but it should be from among a list of providers that can meet their needs, she adds.

"Instead of asking a patient to choose and finding out that the facility may not have a bed or can't provide the needed care, search for available and appropriate facilities and give the patient a list of those," she says. Document in the patient's record that you presented the list, she adds.

The rule also requires the hospital to verify that post-acute providers are in the managed care network if patients are enrolled in a managed care organization, Birmingham adds.

The hospital also must inform the patient or family member of their freedom to choose and identify any skilled nursing home or home health agency in which the hospital has a disclosable financial interest.

The IMPACT Act requirements for post-acute providers to track the same data will enable patients to make a well-informed decision about post-acute care, Magras says. "CMS is proposing that the patient and family must be involved not only in the plan of care in the hospital, but the discharge plan. The new regulations call for helping patients and their families select a post-acute provider by sharing data on quality measures and other information on post-acute providers. It put the power of information in the hands of the patient," Magras says.

The proposed rule outlines specific information hospitals must provide to receiving providers. *(For details, see box on page 22.)*

Hospitals should consider rewriting their transfer forms to make sure they contain all the information necessary to meet the requirement, Dill Calloway says.

If your hospital uses an electronic health record, Birmingham recommends reviewing the Continuity of Care Document in the electronic health record software. "The Continuity of Care Document lists basic clinical information that must be communicated from one provider to another. It is intended to include only the information critical to effectively continue care," Birmingham says.

Birmingham suggests that the case manager review the information contained in the CMS rule to determine whether it will be important to the next provider of care. She cautions case managers to check with their hospital policy and state regulations before sending any information to the next provider.

A webinar, "The IMPACT Act and Its Effect on Discharge Planning Standards," by Sue Dill Calloway will be presented by AHC Media on Feb. 8, 2016, from 3 p.m. to 4:30 p.m. EST. For more information, visit www.AHCMedia.com/IMPACT. ■

Discharge Planning Requirements at a Glance

What Hospitals Should Consider in Evaluating a Patient's Discharge Needs

- Presenting diagnosis or patient's reason for coming to the hospital.
- Relevant comorbidities and medical and surgical history.
- Types of physicians involved in the patient's care after discharge, such as specialists or primary care physicians.
- Location from where patient was admitted.
- Use of community-based services.
- Vital signs including pain level and management strategies.
- Readmission risk.
- Discharge plan from previous hospitalization.
- Relevant psychosocial history.
- Payer status: Medicare, Medicaid, commercial, workers' compensation, no funding.
- Ability to pay for medications, ordered equipment, special dietary needs.
- Ethnic and cultural beliefs and practices related to healthcare.
- Communication needs including language barriers, diminished eyesight and hearing, and self-reported health literacy challenges of the patient or the patient/s caregiver/support person.
- Patient's access to non-healthcare services and community-based care providers.
- The patient's treatment goals and preferences.
- Barriers to the patient's goals and preferences.
- Alternative options for patient's goals and preferences.

Discharge Instructions for Patients Being Discharged to Home

Discharge instructions must be provided at the time of discharge to the patient or the patient's caregiver or support person and the post-acute provider if the patient is referred for post-acute care. They must include, but are not limited to:

- Instruction on post-hospital care as identified in the discharge plan.
- Written information on warning signs and symptoms that may indicate the need to seek immediate medical attention, including who should be called if the warning signs and symptoms exist.
- Information on prescriptions and over-the-counter medications required after discharge including the name (brand name and generic), indication, and dosage of each drug, and any significant risks or side effects of each drug.
- Reconciliation of all discharge medications with medications the patient was taking before discharge.
- Written instructions, either on paper or in electronic format, of follow-up care, appointments, pending or planned diagnostic tests, and contact information including telephone numbers for practitioners involved in follow-up care and any providers or suppliers to whom the patient has been referred.

What to Send to the Receiving Provider at the Time of Transfer

The following information should be sent to post-acute facilities, home health agencies, and other community agencies to which the patient is being transferred. The information should be reviewed by the case managers to determine whether it will be important to the next provider of care.

In addition to a copy of the patient's discharge instructions, the discharge summary, and other documents to ensure a safe and effective transition in care, the transfer information should include:

- Demographic information including name, gender identity, date of birth, race, ethnicity, and preferred language.
- Contact information for the practitioner responsible for the care of the patient and the patient's caregiver or support person, including the name, telephone number, and relationship.
- Any advance directives.
- Patient education provided to the patient or caregiver.

- Procedures, including surgical or diagnostic, that the patient received along with the response and outcomes.
- Diagnoses with ICD-10 code if known.
- Infectious disease status at the time of discharge, if applicable.
- Patient's mental status at the time of discharge.
- Results of laboratory tests and other diagnostic procedures.
- Tests and procedures pending at the time of discharge and how the next provider can access the reports.
- Results of any consultations.
- Functional status assessment including activities of daily living at discharge and projected instrumental activities of daily living.
- Psychosocial assessment and cognitive status.
- Patient's social support.
- Behavioral health issues. (Verify state rules for communicating this information without the consent of the patient.)
- Reconciliation of all discharge medicine with pre-admission medicines, medications during hospitalization including over-the-counter medications.
- All known allergies.
- Immunization record, particularly influenza and pneumonia.
- Current and past smoking status.
- Alcohol or other drug use, legal or illegal.
- Vital signs, including pain level.
- Unique identifiers for any implantable devices, including their intended purpose, patient education information, name and contact information for the physician monitoring the device.
- Any special instructions or precautions for ongoing care.
- Patient's goals and treatment preferences.

What to send to the Practitioner Responsible for Follow-up Care

- A copy of the discharge instructions and discharge summary within 48 hours of discharge.
- Pending test results within 48 hours of their availability.
- All of the necessary information listed above that must be sent to receiving facilities.

Source: 2016 Jackie Birmingham and the Centers for Medicare & Medicaid Services ■

Diabetes program focuses on the basics

Patients learn skills to keep them safe

Recognizing that it's difficult to teach patients everything they need to know about managing their diabetes during today's short hospital stays, Vidant Health has developed and implemented a multidisciplinary model that concentrates on the basics and focuses on making sure patients are safe after discharge.

"There's not a lot of time during a hospital stay for comprehensive diabetes training. We determined that patients need four survival skills: medications, glucose monitoring, hypoglycemia recognition, and having a relationship with a primary care provider in the community," says **Sandra Hardee**, PharmD, CDE, diabetes program manager at Vidant Medical Center in Greenville, NC.

The change to the new model saved the institution approximately $425,000 a year, which translates to an average per-patient savings of almost $35 a year, Hardee says.

The hospital used University Health Consortium data to track length of stay and admission rates for diabetes patients and compared data for nine months before the new model was implemented and nine months after implementation.

"There was no significant difference

in the median length-of-stay or the 30-day all-cause readmission rates when diabetes was the primary or secondary diagnosis. However, these data indicate that the model is working at least as well as the previous model, at a substantial annual cost savings," Hardee adds.

The hospital's established diabetes program employed five nurse educators but the program did not seem to be affecting outcomes, Hardee says. "The program ran by referral and we were touching only about 20% of the diabetes population," Hardee says.

The health system's executive leadership agreed to let the diabetes team develop another model that would reach more patients, provide a consistent message, and lead them to outpatient diabetes resources for ongoing care.

An interdisciplinary team that included pharmacy, nutrition, nursing, and case management collaborated to develop an inpatient diabetes program that uses the resources and expertise on hand to reach all the patients and improve outcomes, Hardee says.

"We knew we had to think outside the box. We conducted a review of the literature and brainstormed about the most important things that the patient really needed to know," says **Amanda Hargrove**, RN, MSN, ACM, administrator for case management service at Vidant Medical Centers.

The team decided that its focus should be on providing information and teaching skills that will keep patients safe, rather than trying to teach them everything about diabetes in a short period of time, she says.

The team then developed a graphic that illustrates what the medical provider, the bedside nurse, the pharmacist, the case manager or social worker, and the nutritionist need to do for all patients with diabetes.

For instance, the bedside nurse assesses patients for educational needs with the goal of making sure the patient understands the four survival skills. The case manager assesses the patient for discharge needs with the goal of connecting the patient to needed post-acute resources. The case manager also makes sure the patient has diabetes supplies, and provides the patient with information on outpatient diabetes educational resources.

"This model helps us become patient-centered and guarantees that we give patients what they need. It's a multidisciplinary effort between the pharmacist, the bedside nurse, and the case manager, with the case manager ensuring that it's all tied together at discharge," Hargrove says.

Every patient with diabetes is automatically enrolled in the program upon admission. "When patients come into the hospital, the nurse determines if they have diabetes as a primary or a secondary diagnosis," Hardee says. For instance, patients hospitalized with pneumonia who also have diabetes receive the inpatient diabetes interventions.

The diabetes model has three different tracks: one for newly diagnosed diabetics, one for patients who were previously diagnosed with diabetes, and one for patients who are new to insulin, Hargrove says.

"This helps us tailor the interventions to the patient's needs. For instance, someone who is a newly diagnosed diabetic needs a nutrition consultation," she adds.

The case managers start the discharge planning process as soon as the nurse identifies which track the patient should be on. They make sure that the patient has a primary care physician and has a follow-up appointment.

"Our providers know that the patient has diabetes and they take this into consideration when developing a discharge plan based on medication and resources the patient needs," Hardee says.

The core team calls on pharmacists and nutritionists to see the patients as needed. "We always call on nutritionists for new diabetics. We bring in a pharmacist for the more complex patients, those who need to transition to a different regimen, and

EXECUTIVE SUMMARY

Vidant Medical Center in Greenville, NC, is saving about $425,000 a year by implementing a multidisciplinary model that teaches patients with diabetes the basic skills they need to stay safe after discharge.

- A multidisciplinary team that included pharmacy, nutrition, nursing, and case management developed the program after data showed that the hospital's traditional diabetes program was reaching only about 20% of the diabetes population.
- The team determined that patients need four survival skills to stay healthy at home: medications, glucose monitoring, hypoglycemia recognition, and having a relationship with a primary care provider in the community.
- The team developed a graphic that illustrates what the medical provider, the bedside nurse, the pharmacist, the case manager or social worker, and the nutritionist need to do for all patients with diabetes. Each member of the team also reinforces the four survival skills.

those with complex educational needs. All of the team members reinforce the four survival skills," Hardee says.

The inpatient team also collaborates with community partners to ensure that the patients get what they need after discharge, Hargrove says.

The case management department maintains a resource index that the case manager can use to print out all the community diabetes resources near the patient's home. Patients who are at low or moderate risk may be referred to a community-based educational class, or to the diabetes education section on the hospital's intranet.

"We connect patients with the resources in the community while they are in the hospital. It may be home health or telehealth or a care coordinator who follows them in the community," she adds.

The hospital team automatically refers at-risk patients to the Vidant Health care coordination team, which provides home visits and services based on each individual patient's needs.

If patients are covered by Community Care Plan of Eastern Carolina, they transition to a case manager from that organization, she adds. Community Care Plan of Eastern Carolina is a regional network within Community Care Plan of North Carolina, the entity that manages much of North Carolina's Medicare funds.

"It a matter of creating a smooth transition and connecting patients with community resources depending on their needs," Hargrove says. ■

Mobile teams fill the gap between the hospital and the community

Clinicians visit at-risk patients at home after discharge

When patients with cardiopulmonary issues either don't qualify for home health services or refuse them, a clinical team from The Valley Hospital in Ridgewood, NJ, visits them at home shortly after discharge and performs a comprehensive assessment of the patients and their home situations, and reinforces the discharge teaching.

The Mobile Integrated Healthcare Program is part of a bigger project to prevent readmissions by filling the gaps between the inpatient setting and the community, says **Lafe Bush**, a paramedic and the hospital's director of emergency services. The mobile teams include a paramedic, a critical care nurse, and an emergency medical technician.

"We believe that no patient should go home without support. Patients with cardiopulmonary disease, especially heart failure and chronic obstructive pulmonary disease, are particularly susceptible to rehospitalization, especially during the transitional period after they first arrive home. This program is another way of getting a home visit for these patients at a time when they are most vulnerable," Bush says.

The program, which began in August 2014, is a collaboration between Valley's Department of Emergency Services and Valley Home Care. The program initially targeted heart failure patients, but has been expanded to include patients who have undergone transcatheter aortic valve replacement.

When patients come into the hospital, the case manager assesses them and stratifies them as to risk for readmission, according to **Robin Giordano**, RN, NP, supervisor of Valley's Outpatient Transitional Care Program. "If the discharge plan calls for home care and at-risk patients don't meet the criteria or they refuse home care, we call in the mobile team," she says.

EXECUTIVE SUMMARY

A clinical team from The Valley Hospital in Ridgewood, NJ, visit at-risk patients at home after discharge if the patients don't qualify for or refuse home health services.

- A mobile team that includes a paramedic, a critical care nurse, and an emergency medical technician visits patients who have been referred by the case managers after a risk assessment.
- The team performs a comprehensive assessment of the patients and their home situations and reinforces the discharge teaching they received in the hospital.
- In most cases, the team makes only one visit but will return if the patient still needs support.

Many of the patients in the program are elderly, but the team sees younger patients as well, Bush says. "It doesn't matter how old or young they are — if there is a need, we send in the team," he adds.

When the team visits, they conduct a full assessment of the patient, including a physical exam, and look for safety issues and other problems in the home. If the team uncovers a social issue, such as empty cupboards or the need for assistance with housekeeping, they call in a social worker. If the patient needs help with transportation to their physician visit, they work with the health system's transportation department to line it up.

The emergency medical technician surveys the home for safety risks, such as how the patient is able to get in and out of the bathtub, and if there are throw rugs or appliance cords that pose a hazard.

The paramedic takes vital signs, performs an EKG, checks the patient's blood sugar, and works with the nurse on medication reconciliation.

The nurse makes sure that the patients have filled their prescriptions and have follow-up appointments with their primary care providers and reinforces the discharge teaching, educating patients on their treatment plan and how to follow it, Giordano says.

"Sometimes it's something as simple as getting them a medication box and teaching them to sort their daily medication," she adds.

Most of the visit involves education, Giordano says. "We know that patients retain only a small amount of information they receive in the hospital. They can absorb the information better when they are at home and comfortable rather than when they're in a hospital bed and ready to be discharged," she says.

Having a healthcare team see the patient's home situation firsthand is invaluable in helping patients follow their treatment plan and avoid emergency department visits and readmissions, Giordano says.

"People often tell you what they think you want to hear. When the team visits patients at home, they often see a whole different world from what the patients reported to the hospital team," she says.

In many cases, the mobile team attempts to persuade patients who have refused home health to accept visits from home care nurses.

"The team members take the time to explain what home care is all about. A lot of times, they think it's around-the-clock service or that someone is coming in to bathe them. We explain that the home care nurse will visit periodically but will not try to take over their lives," Bush says.

In most cases, the mobile team makes only one visit to the patients' homes but will come back if they feel the patient needs follow-up.

"The team makes a second visit if they can tell the patient still doesn't quite understand their discharge plan. We ask if we can come back in two days and check on them again," he says.

The team has the connections to leverage the resources of the entire Valley Health System as well as community and county resources, Bush says.

In one instance, an elderly man with heart failure the team was visiting weekly called in between visits and said he was having trouble breathing. The team went to the home and administered IV furosemide. They referred him to Valley Health's outpatient heart failure program and arranged for transportation through the Valley Health transportation system.

"All of the programs at Valley Health work together to take care of the needs of these patients," Bush says. ■

TJC praises top hospitals in annual report

Hospitals continue to make progress on quality and safety, according to key measures of evidence-based care processes. That's the bottom line from The Joint Commission's (TJC's) 2015 annual report on quality and safety, which summarizes data on 49 accountability measures more than 3,300 TJC-accredited hospitals collected and reported in 2014.

In the report, a total of 1,043 hospitals achieved "top performer" status, a designation that requires a hospital to:

- achieve a cumulative performance of at least 95% on all reported accountability measures;
- achieve a performance of at least 95% on every reported accountability measure with at least 30 denominator cases;
- have at least one core measure set that achieves a composite rate of at least 95%, and within the measure set, achieve a performance rate of at least 95% on all individual accountability measures.

"This is the largest and most diverse set of data TJC has ever collected from U.S. hospitals measuring how well they are providing care for a variety of specific conditions such as heart attack, perinatal care, and children's asthma,"

noted **Mark Chassin**, MD, FACP, MPP, MPH, president and CEO of TJC, when announcing the findings on November 17. "This year, seven new accountability measures were added, including two new measure sets related to tobacco treatment and substance use. We also asked hospitals to submit data on six measure sets, up from four in 2013."

While TJC-accredited hospitals have charted dramatic improvements since TJC's core measures program debuted in 2002, the number of top performing hospitals noted in the report is actually down by 180 from a year ago. Chassin noted that TJC actually anticipated a steeper decline.

"The bar is higher because we added new measures and new requirements this year for the number of measures that had to be reported. We expected the number of hospitals qualifying as top performers and [meeting] this overall metric of 95% would decline a little bit, but it didn't decline by very much," Chassin said. "That is a bit of a surprise. I thought it would decline more."

Chassin noted that in the first year of the "top performers" recognition program, only 405 hospitals or 14% qualified as top performers based on their performance in 2010. This year, more than 30% have earned the recognition, even with more measuring and reporting requirements. Chassin added that another 165 hospitals missed the top performer designation this year by only one measure.

While lauding the top performing participants, Chassin announced TJC will put the program on a one-year hiatus in 2016. During this period, he noted TJC intends to focus its attention on helping accredited hospitals transition to electronic clinical quality measures. Chassin added that TJC this month will launch a new Pioneers in Quality program focused on helping hospitals reach top performer status "in the electronic clinical quality measures world."

Chassin acknowledged that with so many players now engaged in rating hospital quality, people are looking to multiple sources for information. However, he cautioned that not all of the measures tracked and reported hold up to close scrutiny.

"For a number of years … TJC and CMS were nearly perfectly aligned in the definition of measures and in the public reporting of those measures, and the public reporting drove a huge amount of improvement," he said. "Those were the only data on hospital quality that were available, but now the situation is different."

Chassin took particular issue with the way Medicare has added measures that are derived from billing data.

"We don't believe those measures are valid measures of quality. We will also not use outcome measures … that rely on billing data to perform risk adjustment because those billing data don't have any information on the severity of the condition, which is one of the most important things you have to adjust for when comparing different populations," he explained.

Chassin also took exception to the ratings practice of giving hospitals a single letter grade to denote quality.

"That is just demonstrably misleading, because we know … that quality varies enormously within hospitals from one service to another and from one measure to another," he said. "Even if you literally had great quality measures and averaged them across an entire hospital, that average would be very misleading because patients might expect to get whatever that average is in a particular service, but one service is going to be higher than average and one service is going to be lower."

That is why TJC has refrained from coming up with a single measure to denote hospital quality, Chassin said.

"It just flies in the face of decades of research that shows the variability does not allow that kind of measurement to be accurate," he said. "The evidence is crystal clear that quality varies quite a lot within individual hospitals from one service to another and from one measure to another."

How can hospitals try to appease all the players in the hospital quality measurement field?

Chassin encouraged organizations to tune out the "noise" and focus on measures that are most important to their own patient populations. "The most important quality improvement that hospitals can do is to understand what risks their patients are facing, what improvements are necessary for their patients, and to act on those incentives," he said.

"America's Hospitals: Improving Quality and Safety: The Joint Commission's Annual Report 2015" is available at: www.jointcommission.org/TJC_annual_report_2015. ■

COMING IN FUTURE MONTHS

- Shadowing patients helps staff gain understanding
- Tips for spotting patients at risk for readmissions
- How your peers improve patient flow
- What to expect from the various Medicare auditors

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

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CE QUESTIONS

1. The proposed changes in the discharge planning portion of the Medicare Conditions of Participation make it advisable for hospitals to revise their discharge planning policies, according to Sue Dill Calloway, RN, MSN, JD, CPHRM, CCM, CCP. What are the requirements for the revised discharge planning policy?

A. The policy must be developed with input for the medical and nursing staff, including social workers and discharge planners.
B. The policy must be in writing.
C. The policy must be approved by the hospital board.
D. All of the above.

2. The proposed changes in the discharge planning portion of the Medicare Conditions of Participation require hospitals to identify potential discharge needs for every patient within 24 hours of admission and complete the process before the patient is discharged or transferred to another facility, even if the patient stays less than 24 hours.

A. True
B. False

3. The proposed discharge planning regulations require hospitals to provide a discharge summary and discharge instructions to the patient's primary care physician within what time frame after discharge?

A. 24 hours
B. 48 hours
C. Seven days
D. Two weeks

4. When it developed a model for educating diabetes patients, the multidisciplinary team at Vidant Medical Center focused on four skills to keep patients safe, rather than teaching them everything about diabetes during a short stay. What are the skills they determined are most important?

A. Medications, glucose monitoring, hypoglycemia recognition, having a relationship with a primary care provider
B. Change of diet, weight loss, glucose monitoring, follow up with a physician
C. Medications, having a relationship with a primary care provider, weight loss, exercise
D. Medications, glucose monitoring, weight loss, exercise