HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

AHC Media LLC

IN THIS ISSUE

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MAY 2009
VOL. 17, NO. 5 • (pages 65-80)

Take steps now to reduce readmissions, ED visits within 30 days

CMS is considering incentives to reduce avoidable rehospitalizations

When the Obama administration announced its goals for revamping health care, it proposed cutting reimbursement to hospitals that readmit a large number of patients within 30 days of discharge.

The idea is nothing new.

In its proposed changes to the Medicare Hospital Inpatient Prospective Payment System (IPPS) for 2009, the Centers for Medicare & Medicaid Services (CMS) asked for public comments on the application of incentives to reduce avoidable readmissions to hospitals.

The IPPS proposed rule did not include any specific policy regarding readmissions but said it is considering financial incentives as well as nonfinancial incentives, such as public reporting of hospital admission rates.

CMS noted that almost 18% of Medicare patients are readmitted to the hospital within 30 days of discharge, resulting in approximately 2 million readmissions at a cost of $15 billion annually. The agency cited data from the Medicare Payment Advisory Commission (MedPAC): Potentially preventable readmissions cost more than $12 billion a year.

The president's plan proposes bundled payments to hospitals that would cover their own services as well as any services provided by home health agencies and nursing homes in the 30 days following discharge, a move estimated to save $26 billion over 10 years.

As the idea of cutting reimbursement for readmissions is bandied about, hospitals would be well advised to start tracking their readmission rates and developing initiatives to prevent readmissions, advises **Jackie Birmingham**, RN, MS, CMAC, vice president of professional services for Curaspan Health Group, a Newton, MA, health care technology and services firm.

"Once Medicare starts mentioning a change in reimbursement procedures, it is likely to happen sooner rather than later. Hospitals are one

short episode in patient care. Someone needs to monitor the patient's post-acute care and ensure that there is continuity. A system to bundle hospital payments for post-acute services won't be easy but it has merit," she says.

It's not enough for case managers to come up with a discharge plan. They have a responsibility to make sure that the care plan they set up is working, that the supplies the patient needs at home were delivered, that the home health nurse showed up, and that the patient made a follow-up visit to the doctor, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy & Associates LLC, a case management training and consulting company in Huntington, NY.

"With this administration looking at implementing penalties for what is being determined to be 'avoidable' readmissions in less than 30 days, hospital discharge planners and case managers are going to have to do more than just getting [patients] discharged from the hospital. They are going to have to take steps to ensure that the patients stay out of the hospital," she says.

When they are discharged from the hospital, patients may be confused about how to take their medicine and will go home and either not take it or take it incorrectly. A significant number of patients do not leave the hospital with an appointment for a follow-up visit, or if they have one, they don't go to the appointment, says **Brian W. Jack**, MD, vice chair of Boston University Medical Center's department of family medicine, who led a study that concluded that patients who understand their post-acute instructions are less likely to be readmitted. **(For details on the study and how the Re-Engineered Discharge process works, see related article on p. 71.)**

Those gaps in the continuum of care often lead to a patient's clinical condition worsening after discharge to the point that he or she ends up going to the emergency department and being readmitted, he adds.

"Taking care of patients in the hospital is a complex process performed by health care professionals. When they go home, we expect patients to take care of themselves, and they are not prepared to do that. If we spend time with them, educating them on what they need to do after hospitalization, they are better prepared to go home, and that makes the difference," Jack explains.

In today's health care environment, as hospitals are under pressure to discharge patients sicker and quicker than ever, there's an increased risk that patients' conditions may worsen and that they'll be readmitted, Mullahy says.

"Something happens between the time people leave and when they come back in a few days. As case managers, we need to identify what is happening and develop a concerted plan to avoid it," she says.

Identify the types of patients who are frequently readmitted and identify any patterns in readmission, Mullahy suggests.

When you analyze your readmission rates,

Hospital Case Management™ (ISSN# 1087-0652), including **Critical Path Network**™, is published monthly by AHC Media LLC, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ***Hospital Case Management***™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 Mon.-Thurs.; 8:30-4:30 Fri. EST. E-mail: customerservice@ahcmedia.com. Web site: www.ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $469. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $78 each. (GST registration number R128870672.)

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This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 18 clock hours.

This program was approved by the National Association of Social Workers (provider # 886399925) for 18 continuing education contact hours.

The target audience for **Hospital Case Management**™ is hospital-based case managers. This activity is valid 36 months from the date of publication.

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don't look only at diagnoses. Include psychosocial and demographic factors in your analysis, Birmingham suggests.

"Case managers need to go beyond looking at a particular diagnosis for readmission rates and drill down to find the specific population that is being readmitted more frequently," she adds.

Identify patterns in readmissions

Look for patterns in readmissions. Determine if they occur following discharges on a particular day or at a particular time, Birmingham suggests.

"Anecdotally, most readmissions occur among patients who were discharged late in the day on Friday or on Saturdays when staffing is short," she says.

When Birmingham hosted a transitions-in-care seminar for home care agencies and hospital staff, the home care representatives complained that hospitals rush to discharge patients on Friday afternoons to avoid keeping them over the weekend. As a result, home care agencies are challenged to find highly skilled home care staff who are available to care for the patient over the weekend.

Look at the number of readmissions to a specific unit or service line and evaluate the work load of the staff, Birmingham suggests.

For instance, if a medical unit with a patient-to-staff ratio of 25-to-1 has a high rate of avoidable readmissions, this may indicate a need for more staff, she adds.

Compare your readmission length of stay with the length of stay from the previous admission. If the initial hospital stay was lower than the average length of stay, the patient may have been discharged too soon, Birmingham says.

Look at readmissions from specific nursing facilities or home care agencies, as well, to identify any quality issues in post-acute services, she adds.

Lack of patient education can result in a readmission, Birmingham points out.

For instance, a patient may rate his pain as a Level 4 while he is in the hospital, but it may rise to a Level 5 after he gets home, and the family may call the doctor, saying the pain is worse.

"On weekends, there is an on-call physician who may not be familiar with the patient's condition and may send him to the emergency department. They aren't going to send a patient home in the middle of the night, so they'll readmit him," she says.

To avoid such a situation, the hospital case managers should warn the patient what to expect when he or she gets home and what symptoms indicate that he or she should call the doctor.

When you determine which patients are likely to be readmitted, develop a specific plan for following up on them, Mullahy suggests.

Decide when you will call, what questions you will ask, and what signs and symptoms indicate that the patient may be having problems.

Consider making follow-up calls a few days after discharge to the patients who may be likely to have problems that could lead to readmission.

"You don't need to do this with every patient, but every case manager knows which patients and which diagnoses are notorious for having problems after discharge," Mullahy says.

For instance, if a patient with a history of diabetes has surgery and his blood sugar level has been unstable prior to surgery and somewhat difficult to control while he is in the hospital, he is more likely to develop an infection in his wound, Mullahy points out.

In that case, the case manager should educate the patient and family members on symptoms to watch for and follow up with a call to find out if the patient's temperature is elevated, determine the patient's blood sugar levels, and find out if the wound is draining.

"If the patient is having early signs of a wound infection and sees the doctor, it will avoid an emergency room visit and hospital readmission," Mullahy says.

Another example would be to follow up with an elderly patient who is on five or more medications.

"It makes sense for a pharmacist to call after discharge to determine medication compliance, and there are a few hospitals that are utilizing this innovative approach," Mullahy says.

"There are so many opportunities to help patients avoid readmissions. No one is saying that hospitals make a follow-up call to every patient, but it makes sense if you stratify your population and identify who has risks for readmission," she says.

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CMs help the chronically ill stay out of the hospital

Program saves $1.4 million on just 79 patients

A community case management program for clients with complex conditions has significantly reduced emergency department (ED) visits and inpatient admissions at Poudre Valley Hospital, resulting in a savings of nearly $1.4 million for a sampling of clients in just six months for the Fort Collins, CO, health system.

The hospital provides community case management as a free service in order to help clients stay healthy in their homes and cut down on unnecessary inpatient admissions and ED visits, says **Donna Poduska**, MS, RN, NE-BC, NEA-BC, director of resource services for the 225-bed hospital.

"This is a community benefit completely sponsored by the hospital. In the end, it is saving the hospital money because we are implementing preventive measures that help keep the patients healthy and out of the hospital," she says.

The savings were calculated by subtracting hospital reimbursement from charges for 79 clients in the six months before they were in the program and comparing it to charges minus reimbursement for the six months after they began the program.

Before they began receiving community case management services, the 79 clients made 84 visits to the ED and experienced 73 inpatient visits. In the six months following their enrollment in the program, ED visits dropped by 48% to 44 and inpatient visits declined to 35, a 55% drop.

The hospital saved $1.4 million on 79 clients in the six months after it started the program compared to the previous six months. The total charges vs. reimbursement for the 79 clients was $1,924,000 in the six months before the program started and dropped to $537,000 after six months of community case management visits, a 72% reduction in financial loss to the hospital for emergency and inpatient services. **(For a look at how the program works, see the related article on p. 69.)**

At the same time, the program saves clients thousands of dollars a year by helping them access community resources that can provide medical supplies, equipment, transportation, discounted housing repair services, and in-home services, says **Cyndy Luzinski**, MS, RN, one of the original case managers in the program.

Poudre Valley Hospital is the only hospital in a community of 140,000 and has been designated a Magnet Hospital for Nursing Excellence since 2000, been named a Solucient Top 100 Hospital, and received the Health Grades Distinguished Hospital Award for Patient Safety in multiple years.

The community case management program was among the hospital programs recognized when the health system was awarded the 2008 Malcolm Baldridge National Quality Award.

Community case management is provided by a group of advanced practice nurses and licensed clinical social workers who coordinate care for clients who are chronically ill with complex medical and psychosocial needs, and who do not qualify for other coverage for home care services.

Poudre Valley Health System began the program in 1995 when it appeared that capitated medicine was coming to the area. Capitation never materialized, but the program was a big success.

Focus on utilization issue

"We were looking at utilization issues. One of our big concerns was that clients with chronic conditions were coming back to the emergency room and being readmitted. Elderly patients with chronic illnesses were showing higher readmission rates and emergency department visits," Luzinski says.

The program began with two nurse case managers and one social worker case manager who worked with more than 180 clients. Now, the program is staffed by six case managers (five nurses and one social worker) who visit about 400 clients a year, seeing each client an average of 16 times a year.

Patients eligible for the program have complex medical and psychosocial needs and do not have reimbursement for some post-acute services, such as home health services.

They often have incomes that are too high for them to qualify for publicly funded support services but not enough to pay out-of-pocket expenses.

Clients in the program typically have limited or no family support system and have limited knowledge about how to access community services. They have a low rate of compliance with the plan of care established by their physicians.

"Most of them want to be compliant with their treatment plan, but they find it extremely difficult to do so. The cause of their lack of compliance may be that they don't understand the plan of care or it may be that they can't afford their medication. These are the people that typically fall through the gaps in the system. We are trying to fill the gaps," Poduska says.

Typical diagnoses include congestive heart failure, chronic obstructive pulmonary disorder, hypertension, and diabetes, often with multiple comorbidities.

The program originally targeted the frail elderly but was expanded to include younger clients, Luzinski says.

"The majority are elderly, but we don't have an age limit. We're seeing more younger people with complex chronic conditions," she reports.

Many of the younger chronically ill clients have cardiac issues and are referred because they have complex psychosocial issues, she adds.

The case managers have an office in the hospital but do most of their work in the field using laptops and PDAs to maintain a list of community services and other resources, Poduska says.

They meet with each other at least once a month to brainstorm about difficult clients and share information on community services.

They have an average caseload of 47 clients at a time and work with them until their identified goals are met and their conditions are stable. A few clients remain in the program indefinitely because they can't manage without support.

The case managers get referrals from physicians, the hospital, community agencies, and other families who have benefitted from the service.

The referrals also come to the inpatient case management/discharge planning/counseling office where the secretary refers the new patients to the community case managers.

The community case managers screen the referrals to eliminate potential clients who are not appropriate for the program. In 2007, the team received 302 referrals and did not open 76 of them because they were eligible for other services such as home care. Another 49 couldn't be reached or refused to participate in the program.

*(For more information, contact **Donna Poduska**, MS, RN, NE-BC, NEA-BC, Director of Resource Services, Poudre Valley Hospital, e-mail: ddp@pvhs.org; **Cyndy Luzinski**, MS, RN, Community Case Manager, e-mail: cll3@pvhs.org.)* ■

Community CMs bridge gaps in the continuum

Clients get help navigating system

When an elderly woman continued to have elevated blood pressure after her physician prescribed a medication regimen, the doctor assumed the patient was confused and not taking her medication properly.

That's where **Cyndy Luzinski**, MS, RN, came in.

Luzinski, a community case manager for Poudre Valley Health System in Fort Collins, CO, had helped the client manage the ordering and administration of her medication and had her use a pillbox to facilitate compliance. She knew the woman was taking her medication correctly.

"I talked to the physician and convinced him that despite previous confusion with taking the medication correctly, the client now was taking the medicine as prescribed. The doctor added another medication, which solved the problem. If I hadn't been there to advocate for the patient, the physician might have continued to assume that the blood pressure elevation was because the client was confused and noncompliant with her medication," she recalls.

Without a case manager to monitor the client, her medication compliance and blood problems likely would have continued, causing her to be hospitalized, Luzinski says.

Meeting a need

Luzinski is one of six community case managers who help patients from Poudre Valley Health System learn how to navigate the health care system, make lifestyle changes that will keep them healthy, follow their treatment plan, and avoid unnecessary hospitalization and emergency department visits.

"Our clients are those who might otherwise fall through the cracks in the health care system. We meet a need in the community and bridge the gaps in the continuum of care to help people stay independent in their own homes," Luzinski says.

When they get new clients, the case managers make an appointment to see them in their homes to assess the situation.

On the first visit, the case managers complete a complex assessment that includes information on the client's physical issues, psychological health,

the client's family and community support, and whether he or she has advance directives.

They perform a noninvasive physical assessment, checking the client's heart, lungs, blood pressure, and signs of edema.

They develop individualized care plans that may include talking to the client's physician, accompanying the client to office visits, assistance with medication management, and coordinating transportation.

"The relationship they build up with the clients is immense. They develop rapport and trust and can be the eyes and ears of the primary care provider. Because they are in the home and work closely with the clients, they can identify and solve problems that the physician might not know about until the client is admitted to the hospital or visits the emergency room," says **Donna Poduska**, MS, RN, NE-BC, NEA-BC, director of resource services for the 225-bed hospital.

Link to system, community

The case managers help the clients negotiate the health care system and learn about and sign up for community resources for which they qualify.

For instance, the case managers help the clients sign up for Meals on Wheels or transportation assistance. If a client wants to stop smoking, the case managers help him or her access a smoking cessation program and put him or her in touch with community agencies that will pay for a patch if the client will go for counseling.

The case managers have helped some clients who qualify for Medicaid enroll in the program. When Medicare rolled out its prescription benefit, the case managers spent a lot of time helping their clients determine which program was best for them and helping them sign up for the benefit, Poduska says.

Many of the elderly clients are taking multiple medications and need help with medication management.

"Some of them have so many prescriptions that it's overwhelming. They won't say so at the doctor's office, but some of them get home and decide that their medication regimen is so confusing that they won't even deal with it," Poduska says.

The case managers follow up with the physicians to ensure that the medication the client is taking is the medication prescribed. The case managers help the clients learn how to use a pillbox or develop another system for taking medication.

"We do whatever we can to help them comply with the treatment plan. Many times, the patient can't remember what the doctor said or is confused about following a complicated plan," Luzinski says.

Nutrition support

For many patients, nutrition is a problem because they have difficulty cooking their meals.

"They don't know about community resources. We can help them find someone they can hire to come in and fix their meals or refer them to home- and community-based services through Medicaid that provide meals and assistance with household chores," Luzinski says.

Sometimes the case managers can mobilize neighbors or people from the client's church who can provide meals or household help.

The frequency with which the community case managers visit their clients ranges from once a week to once a month, depending on the clients' needs.

Typically, the case managers visit once a week in the beginning, then taper off as they connect the clients with resources in the community.

"We follow them as long as it takes to get them back on track. If they just need to identify and connect with resources, we will work with them for a short time but let them know that they can always call us back. We see some of them for a long time if they are really having problems managing on their own," Luzinski says. ■

Heart failure advocates help patients comply

Focus is on self-management, empowerment

Having heart failure advocates work with discharged patients to help them self-manage their care cut the rate of readmissions within 30 days from about 20% to 5%-6% at six hospitals that are part of the Catholic Healthcare Partners health care system.

The project was funded by a grant from the federal Agency for Healthcare Research and Quality (AHRQ), awarded to the five-state health system in 2002.

Although funding for the project ran out in 2006, and the last patient advocate position was

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CRITICAL PATH NETWORK™

Study shows readmissions drop when patients understand discharge instructions

Study demonstrates value of transitions in care

Patients who have a clear understanding of their after-hospital care instructions are 30% less likely to be readmitted or visit the emergency department (ED) than patients who don't have that knowledge, according to a study at Boston University Medical Center.

The results of the study have implications for the quality of care and costs for the more than 38 million hospital discharges each year, says **Brian W. Jack**, MD, who led the study conducted by a research team at the medical center's department of family medicine.

"About 20% of patients have an adverse event within 30 days after discharge from the hospital, and some of these events lead to preventable emergency department visits or readmissions. Our study showed that preparing people for what they need to do when they leave the hospital has a tremendous potential for improving the patients' recovery and saving health care dollars," he explains.

The hospital discharge process requires communication among the inpatient care team, the patient's primary care provider, the patient and his or her family, and community services, Jack reports.

Patients often leave the hospital without fully understanding their follow-up care, such as how to take their medication or when to see their physician for a follow-up examination or testing, he says.

The problem is compounded when hospitalists care for patients in the hospital and the primary care provider is not fully informed of what happened during the hospital stay or, in some cases, that the patient has even been hospitalized, Jack adds.

"Now that more and more hospitalists are following patients while they are in the hospital, there are more gaps in transitions of care. There rarely is any direct communication between the hospital and the ongoing provider; and research has shown that in a third of the cases, the primary care physician had not received a discharge summary when patients made their first follow-up visit," he reports.

As a result, patients often do not receive recommended tests after hospitalization or, if the tests are done in the hospital and the results aren't back before the patient is discharged, no one follows up on the results, Jack adds.

Re-Engineered Hospital Discharge Program

Boston University Medical Center's research team developed a Re-Engineered Hospital Discharge Program (RED) over a five-year period with grants from the Agency for Health Research and Quality (AHRQ) and the National Heart, Lung, and Blood Institute.

The multifaceted program is designed to educate patients about their post-discharge care plans, ensure that patients receive the recommended follow-up care, and increase communication between the hospital and the patients' primary care physicians.

The team started by identifying the steps in the discharge process, determining where the process

Components of the Re-Engineered Hospital Discharge

- ☐ **Educate** the patient about the diagnosis throughout the hospital stay.
- ☐ **Make** appointments for follow-up and post-discharge testing, with input from the patient about the time and date.
- ☐ **Discuss** with the patient any tests not completed in the hospital.
- ☐ **Organize** post-discharge services.
- ☐ **Confirm** the medication plan.
- ☐ **Reconcile** the discharge plan with national guidelines and critical pathways.
- ☐ **Review** with the patient appropriate steps of what to do if a problem arises.
- ☐ **Expedite** transmission of the discharge summary to clinicians accepting care of the patient.
- ☐ **Assess** the patient's understanding of this plan.
- ☐ **Give** the patient a written discharge plan.
- ☐ **Call** the patient two to three days after discharge to reinforce the discharge plan and help with problem solving.

Source: Boston University School of Medicine.

breaks down, and then developed a discharge checklist that details what should be completed to ensure that the patient can be safe at home. **(For details of the checklist, see the chart, above.)**

With the help of graphic artists and health literacy experts, the team developed a six-page spiral-bound color booklet called the "After Hospital Care Plan" that contains individual information for each patient, depending on his or her condition, medication, and discharge instructions.

The booklet includes the reason for hospitalizations; photographs of the patient's doctor and nurses; an illustrated description of the discharge diagnosis and information about what to do if a problem arises or the patient's condition changes; a list of their medications and a color-coded schedule for taking them; a list of tests with pending results at discharge; a list of follow-up appointments with directions for getting there; and a calendar of what the patient should do for the next 30 days.

The study participants were 749 hospital inpatients who were being discharged to the community. Patients who were admitted from a skilled nursing facility or another hospital or were admitted for a planned hospitalization were not included. About half of the participants received the RED checklist while the remainder were discharged in the typical manner.

During the initial study, RNs called "discharge advocates" were assigned to coordinate the discharge for patients in the intervention group. They worked with the treatment team to develop the discharge plan and educated the patients to prepare them for discharge. They arranged follow-up appointments, ensured that the patients understood their medication regimen, and conducted patient education using the individualized instruction booklet. The discharge advocates spent approximately 30 to 60 minutes speaking with each patient throughout his or her hospital stay.

On the day of discharge, a research assistant faxed the discharge summary and the After Hospital Care Plan to the patient's primary care physician.

A clinical pharmacist called patients after discharge to review medications and reinforce the discharge plan.

The study found that total costs (a combination of actual hospitalization costs and estimated outpatient costs) were an average of $412 lower for patients who received the complete intervention than for those who did not.

The 370 patients who received the RED process had 30% fewer subsequent ED visits and readmissions than the 368 patients who did not.

About 94% of patients who participated in the RED program left the hospital with a follow-up appointment with their primary care physician, compared to 35% of patients in the control group.

The pharmacist who contacted the patients after discharge found that 65% of them had at least one medication problem and 53% needed corrective action, such as the pharmacist contacting the subject's primary care physician.

The team is currently conducting a study with patients who receive individually tailored discharge instructions at their own pace from a virtual discharge advocate, or "Louise," an animated

character who simulates face-to-face interaction between a patient and a nurse and runs on a touch-screen display mounted on an articulated arm attached to a mobile cart.

The patients receive the same individualized After Hospital Care Plan booklet, but the teaching is done by the virtual discharge advocate, which educates patients about their post-discharge self-care plans. The educational sessions include information on diagnoses, medications, follow-up appointments, special diets, and exercise regimens.

"Nurses are busy, and we couldn't ask the nurses to spend the time that is needed on discharge education. We are testing a health information technology system to determine if it works as well as a having a nurse teach a care plan," Jack says.

Patients like the virtual discharge advocate because they can go at their own pace and come back to areas they don't understand, he says. In a pilot study, 74% of patients said they preferred receiving the discharge instructions from the virtual discharge advocate.

After completing the discharge instructions from the virtual nurse, the patients take a test that determines how well they understand their post-hospitalization care plan. The floor nurse prints the test results and can go in and reinforce the teaching, if necessary, Jack says.

(For more information, contact: ***Brian W. Jack****, MD, Boston University Medical Center Department of Family Medicine, e-mail: Brian.Jack@bmc.org.)* ■

ED triage improves patient flow

Rapid care area moves patients through system

A new emergency department (ED) triage system at Baptist Hospital in Pensacola, FL, decreased the time that elapses between when patients arrive and when they are treated by 33%, slashed the number of patients who left without treatment by 50%, and cut 20 minutes off the total turnaround time from when patients arrive at the ED and when they are discharged or admitted.

While the ED census remained stable, the total turnaround time dropped from an average of three hours and 35 minutes in the year before the program started to an average of three hours and 15 minutes in the first year of the program.

"In the world of emergency departments, that's a significant time improvement. We treat about 60,000 patients a year, so that's a tremendous amount of nursing time saved," reports **Michael Dolister**, MD, assistant chief of staff and ED physician.

CM deals with admissions

The hospital has a case manager on site in the ED whose duties include assuring that patients meet admission criteria, are admitted in the appropriate status, and that preadmission certification and other details required by the insurance company are completed.

When patients don't meet admission criteria, the case manager helps find an alternative setting of care, such as a nursing home, or lines up home health services.

"The case manager is involved in all the admissions, as well as helping to expedite patient flow in the emergency department," says **Cindy Heidorn**, director of emergency trauma.

Before the hospital revamped the ED in 2007, a multidisciplinary team analyzed the hospital's patient flow, looked at all the obstacles that the staff encounter in moving patients quickly through the continuum, and evaluated the most effective way to safely move patients through the ED.

The team created workgroups to generate ideas from the staff and ED physicians, and then educated the entire staff about the new processes, reports **Paul Ropp**, BSN, CEN, RN, who led the educational effort.

In the past, when patients came in early in the day and rooms were available, the patients were not placed in the room immediately, which began to cause backlogs by late morning.

"Because we have limited capacity, we would reach a saturation point and patients would be left sitting in the waiting room," Dolister says.

The new system triage-bypass allows the ED staff to attend to patients more quickly and admit or discharge them before volumes begin to peak, he says.

"Bypassing triage allows patients to be immediately directed to an available room where the triage and nursing assessment can begin. Otherwise, less acute patients are required to remain in a queue in the waiting area of the emergency department until

an RN can perform this function," he adds.

The hospital's ED uses the emergency severity, index, which stratifies patients according to their levels of severity.

Level 1 patients have emergent needs, such as cardiac arrest or uncontrolled bleeding, and must be seen immediately. Those on Level 2 have urgent needs, including signs of a stroke or heart attack, and should be seen quickly. Level 3 patients are acute with problems such as abdominal pain, vascular bleeding, or major vomiting.

Patients on Level 4 have chronic conditions or minor orthopedic injuries and may need X-rays. Level 5 patients are stable and typically don't require lab or X-ray services.

"In the past, Level 1 and 2 patients were brought back to the treatment rooms rapidly. Patients on Level 4 and 5 with lower acuity were taken to the fast-track area and were treated fairly quickly. Level 3 patients often waited the longest because they would get bumped when patients on Level 1 and 2 came in," says **Sally Campbell**, RN, MH, CRNI, ED triage nurse.

Benchmark other hospitals

When they studied what other hospitals had tried, the team determined that many hospitals had tried adding a midlevel provider to their triage staff, but had determined that it wasn't an effective solution for them.

"We chose to add an experienced nurse to the triage area during peak hours to get the necessary tests and evaluations on the medical staff-approved clinical pathways started before the physician sees the patient," Dolister reports.

Patients who are on Levels 1 and 2 of the severity level still are immediately brought back to the treatment rooms. Patients with the least severity, on Levels 4 and 5, are triaged to the fast-track area.

Level 3 patients, those who need a work-up but do not have emergent needs, now go to the rapid treatment area, a separate room with six chairs, where Campbell completes the nursing assessment and orders work-ups and procedures, such as X-rays and urine tests, using physician-driven clinical pathways.

In the past, those patients would have been triaged to the waiting room until a treatment room was available.

"Now the blood is drawn and the initial orders have been processed before the physician sees the patient. This is very effective in getting the treatment started," Dolister says.

The hospital has used clinical pathways in the ED for 11 years.

"The nurse can drive those even when a patient is already in a room by using physician-driven order sets," Dolister says.

The hospital has a process in place that allows the ED physicians to write bridge orders for patients who have been evaluated and stabilized by the ED staff.

"It often takes a while for the admitting physicians or the hospitalist service to return a page and issue the orders. While we are waiting, the bridge orders allow us to get the treatment started," Dolister says.

Follow-up

At Baptist, members of the ED leadership team make follow-up calls to patients after an ED visit to get their input on their hospital experience, particularly how the discharge instructions were delivered.

The ED director, the clinical manager, the educator, the trauma coordinator, and the ED analyst coordinator all make five calls every day, which represents approximately 15% of the daily ED volume.

Each one is assigned an increment of time in a 24-hour day and they make random calls to patients who were seen in the ED during that time frame.

"It gives us a wonderful window into what happens when people come into the emergency department. If their perception was that the department was unresponsive to their needs or they were kept waiting a long time, we can immediately look at the situation and determine how to correct it," Heidorn says.

The telephone calls have enabled the administration to make changes to improve patient satisfaction, she adds.

For instance, the team found that many patients with nonemergent issues wanted an explanation of how long they were going to have to wait and why.

"If patients are going to have a test, and it takes 30 minutes for the results to be ready, we find our patients are most satisfied if we let them know. This helps them understand why they are waiting and also manages their expectations," Heidorn adds.

*(For more information, contact **Cindy Heidorn**, Director of Emergency Trauma, Baptist Hospital, Pensacola, FL; e-mail: cheidorn@bhcpns.org.)* ■

(Continued from page 70)

eliminated in June 2008, private insurers and other entities have expressed an interest in reviving the initiative, says **Margie Namie**, RN, MPH, CPHQ, vice president of quality for Mercy Health Partners Southwest Ohio.

"The program was highly effective, but we were not able to continue to support the program when the payment system didn't support it. Payers are looking for solutions to patient noncompliance and rehospitalization. We are hoping to start something like this program again," she says.

AHRQ heart failure program

Catholic Healthcare Partners participated in an AHRQ program to improve care for heart failure patients by promoting consistent use of evidence-based guidelines.

"Because our strategic plan focused on chronic illness and addressing the continuum of care, our goal went further than just meeting the care recommended in the core measures and included reducing unnecessary readmission," Namie says.

When the project began, a multidisciplinary team tracked the readmission rates within 30 days of discharge of patients with heart failure who were readmitted for any reason.

The main cause of readmission was failure to adhere to the plan of care, because of real or imagined barriers — including medication issues — failure to stay on a salt-free diet, and lack of understanding of what to do when symptoms worsen, Namie says.

"We quickly identified that we did not have people on staff who could aid the patient in transitioning from the hospital to home," she adds.

The health system created the heart failure advocate position to assist people after discharge. The advocates were nurses who worked with the patients to help them set goals, to overcome barriers to appropriate management, and to identify early signs of relapse and get appropriate help.

"What made this unique over other case management programs was that the nurses worked toward patient self-management and empowerment. Rather than just calling the patients every few weeks, they helped the patients and caregivers learn to effectively manage on their own. There was a small percentage of patients we were not able to impact, but we could improve compliance of most of them once we assisted them in setting goals," Namie says.

The nurses received clinical education on heart failure through Cleveland's Case Western Reserve University. The health system provided training on how to communicate with patients and physicians and ongoing education and training from advanced practice nurses.

"We gave these nurses the training they needed to assume a nontraditional role," Namie reports.

The nurses managed the care of 30 to 40 patients at a time and followed them for about three months. If a patient was extremely fragile with ongoing barriers to compliance, the nurses worked with them for six months to a year.

"Most of the intense work with these patients was within the first two months," Namie says.

The nurses saw the patients while they still were in the hospital and visited them in their homes and during doctors' visits when appropriate.

"The interventions were effective because the nurses created very individualized care plans for each patient," Namie says.

Many heart failure patients have difficulty interacting with their physicians, particularly when their symptoms exacerbate, she points out.

For instance, if patients start to gain weight and call their physicians' office, they are likely to speak to someone who is not a clinician and get an appointment to see the doctor in two weeks. By that time, they're already back in the hospital, Namie adds.

"The nurses helped the patients figure out what they needed to say to the physician's office in order to get an appointment that day. This empowered the patients to handle the situation on their own later on," she says.

Medication issues, particularly the cost of medication, were another barrier to compliance among the patients in the project.

"Patients with heart failure take multiple medications, and we found that patients who couldn't afford all of them would pick the top five on the medication list and fill those. We don't prioritize medications that way, but some patients think they were listed in order of importance," Namie says.

Upon first visit

When the nurses met with a patient for the first time, they reconciled the patient's list of medications with what was on record with the physician's office and what the patient had been taking

before he or she was hospitalized. They made sure the patient was taking the right medications and educated him or her on when to take which medication.

The nurses helped patients who couldn't afford their medication sign up with medication assistance programs. They helped them find a temporary source of medication until the patients were approved for a pharmaceutical program. For instance, patients in the Youngstown, OH, area who couldn't afford their medication were eligible for up to 60 days of medication through St. Elizabeth Health Center.

Compliance with low-salt diet

Difficulty following a low-sodium diet was another barrier to compliance.

Many of the heart failure patients lived alone and depended on canned foods because they are inexpensive and easy to prepare. The health system created standardized heart failure educational materials, written at a fourth-grade level, to give patients ideas on how to follow a low-salt diet. The nurses worked with the patient to help them identify low-salt foods that fit their budgets.

If the patients were reluctant to give up canned foods, the nurses taught them to look for canned food with reduced sodium or to thoroughly rinse the food before cooking.

(For more information, contact: ***Margie Namie****, RN, MPH, CPHQ, Vice President of Quality, Mercy Health Partners Southwest Ohio. E-mail: mwnamie @healthpartners.org.)* ■

Don't let the IM fall through the cracks

CMS: Still notify patients of discharge rights

Hospitals still need to be vigilant about issuing the Important Message from Medicare (IM), notifying Medicare patients of their right to appeal their discharge, their financial responsibilities, and how to appeal their discharge, warns **Jackie Birmingham**, RN, MS, CMAC.

"When I speak to case managers and discharge planners, I am getting questions that indicate that some hospitals may be slacking off in issuing the IM. There seems to be a rumor that Medicare isn't paying attention to compliance with the IM regulations. This is not the case," adds Birmingham, vice president of professional services for Curaspan Health Group, a Newton, MA, health care technology and services firm.

The Centers for Medicare & Medicaid Services (CMS) issued a revised "Interpretive Guidelines" in October 2008 that is to be used by surveyors when they visit the hospital to determine if the Conditions of Participation are being followed.

"Hospitals must establish and implement policies and procedures that effectively ensure that patients and/or their representatives have the information necessary to implement their rights," the Interpretive Guidelines for the Conditions of Participation state.

To whom does the IM apply?

The rule applies to traditional Medicare beneficiaries, beneficiaries enrolled in Medicare Advantage programs, and other Medicare health plans that are subject to Medicare regulations.

The Important Message from Medicare must be delivered within two calendar days of inpatient admission and must be signed by the beneficiary or his or her representative and dated, and a copy must be given to them.

If a patient stays more than two days in the hospital, he or she must receive a copy of the original signed form within two calendar days of discharge.

CMS allows hospitals to issue the IM at preadmission, but not more than seven calendar days before the admission.

"The second copy still needs to be given. It doesn't have to be signed by the patient, but the hospital still has to prove that it's been given, so signing is still a good idea," Birmingham says.

According to the survey procedures issued by CMS, the surveyors will determine the hospital's policy for notifying patients of their rights and determine that the information provided to the patients complies with federal and state law. They will review the records and interview staff to determine how the hospital communicates information about their rights to diverse patients and whether they use alternative means such as signs and interpreters to communicate patient rights.

(Editor's note: For more information, see: http://www.cms.hhs.gov/manuals/downloads/som107ap_a_hospitals.pdf.) ■

ACCESS MANAGEMENT
QUARTERLY

Strategies to increase your preauthorizations

One hundred percent of scheduled cases authorized — that is the goal set by Boston-based Massachusetts General Hospital's financial access unit.

"If we don't have an authorization and referral for anything that is scheduled, and if it's not going to be postponed until we do get the authorization, then it has to go through an escalation process," says department manager **Joe Ianelli**.

The department uses two primary tools to ensure prior authorizations are obtained: One is a "48 hours" list, and the other is a "bill hold."

The "bill hold" involves accounts that have been discharged but still lack authorization. "This is typical for emergency admissions, as insurance companies may request clinical documentation as they are working on their authorization process," says Ianelli. "Technically, we should have no elective accounts on the bill hold, as our standard is to ensure authorization before the visit takes place."

As for the "48 hours" list, "anything that's been in-house longer than two days without an authorization gets really close scrutiny," he explains. "If it's an elective procedure — meaning scheduled — we really have to have the authorization all sewn up before the patient even gets in the door."

Delays mostly in ED

Typically, the delays involve patients admitted via the emergency department who haven't yet been authorized. If the authorization isn't obtained, for whatever reason — the patient's physician booked the procedure late in the process, or there are difficulties with the insurance company — an escalation process is used. "We get the chief medical officer involved, and they have a discussion, physician to physician, about whether the case should move forward," says Ianelli.

However, most physicians "want to do the right thing, financially and clinically, for everyone involved," he reports, "and if they can't

CNE *questions*

17. According to the Centers for Medicare & Medicaid Services, what percentage of Medicare patients are readmitted to the hospital within 30 days of discharge?
A. 10%
B. 12%
C. 18%
D. 20%

18. Before they began receiving community case management services, a sample of 79 patients at Poudre Valley Hospital made 84 visits to the emergency department (ED) and had 73 inpatient admissions. How many ED visits did those same patients make after six months of community case management services?
A. 44
B. 55
C. 66
D. 72

19. At Catholic Healthcare Partners system, when heart failure advocates worked with heart failure patients after discharge, their rate of readmission dropped from about 20% to what percentage?
A. 2% to 3%
B. 4% to 5%
C. 5% to 6%
D. 7% to 8%

20. According to Jackie Birmingham, RN, MS, CMAC, hospitals are having trouble complying with instructions on using the Important Message from Medicare.
A. True
B. False

Answer key: 17. C; 18. B; 19. C; 20. A.

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

justify the case as emergent, they will be amenable to postponing the procedure. We do take the clinical imperative as the priority. "

At North Shore-Long Island Jewish Health System, patient access has increased the percentage of times that staff secure authorization for scheduled hospital services from about 75% of the time to about 95% of the time.

"This has measurably reduced our denials and back-end rework, and has had a positive impact on our agings and cash flow," says **Frank Danza**, vice president of revenue cycle management "Equally as important, we have been able to isolate those scheduled cases where the payer is unwilling to provide an authorization for an inpatient level of care, before the patient receives the service."

This allows patient access staff to work with the doctor both before and on the day of service to make sure that he or she has documented the clinical rationale for the admission in the admitting order and related notes. "We expect to see a measurable decrease in inpatient denials and resulting downgrades to outpatient reimbursement levels during 2009," says Danza.

Financial rounds meeting is key

Massachusetts General's patient access staff attend a weekly "financial rounds" meeting every Wednesday at 10 a.m, to review the status of all outstanding authorizations. "This is something I've been doing every week since I got here seven years ago," says Ianelli.

Attending the meetings are a supervisor and two team leads in the insurance group, and two supervisors and one team leader in the financial counseling group, as well as all frontline staff. "We are one contiguous group, and we talk to each other a lot," he says. "We have SharePoint sites where we post policies and procedures so people don't have to have their own libraries — it's all right there for them."

Ianelli says of the three major payers in Boston, two now are saying there could be significant changes in their authorization processes. The constant changes, he says, mean that "I need really smart, responsive staff."

The financial rounds meeting is based on the model of medical rounds done by physicians to discuss their patients as a group. "I do the same thing here financially. I want to know what's going on with cases that haven't been posted yet, that don't have authorization," says Ianelli. "We have literally everyone in the room, and I go around one by one."

First, Ianelli goes around the room to ask the insurance verifiers, "Who's on the 48-hour list that you haven't been able to post?

"And I want to hear the reasons why," he says.

The purpose isn't to intimidate staff or put anyone on the defensive — it's to solicit ideas to get to the bottom of how the authorization can be obtained. "If there is a tough motor vehicle accident and somebody isn't responding, somebody may say, 'Have you tried calling the police station?' or 'Maybe we should get legal involved,'" says Ianelli. "We try to use a team model approach to get the authorization."

Feedback appreciated

Staff appreciate getting feedback on tough cases from other members of the team. "I think at first, the staff felt nervous going to a meeting like that; but over time, they felt really supported," says Ianelli. "Everyone is in on the decision, and people who have been doing this for a long time can share their knowledge. We have been working this way for a very long time."

For each case, Ianelli hears from the financial counselors as to whether the patient is already admitted or is coming electively, and whether he or she is self-pay, a pending Medicaid authorization, or otherwise. "I want to hear where we stand on the process — is it a done deal? Do we need to postpone?" he says.

Financial counseling staff can help move the process along for the most difficult cases. "If my insurance verifiers are having a hard time because there are some insurance issues, then we can get financial counseling involved at the earliest possible stage, so that we can possibly help the patient to apply for public benefits or to set up payment plans," says Ianelli.

Denials are learning tool

Ianelli says if a claim is denied, the insurance team supervisor, Ianelli's direct report, is the one who handles the appeals. "So, when we mess up, we are responsible for trying to fix it," he says. "The clinical appeals are, of course, handled by case management, but the technical denials come right back to haunt us."

For this reason, Ianelli says he tells staff, "'Deal with it now, or it's going to be a ghost — it will come back to haunt you. So, if it slides by and I

don't hear about it, it's going to come back and it will be worse.'"

Learn from denials

Denials are used as a learning mechanism. "We do 65,000 to 75,000 cases annually, and over 6,000 cases a month, with about 15 people; so, it's a huge work volume," he reports. "Sometimes, it's hard to get at the root cause of where the problems are."

The patient access supervisor has to figure out where the fault lies. For example, "Is Payer X acting differently? Did something change over at the payer, or do we have a staff member who is making mistakes?"

"We certainly push back with the payers, and payers typically respond if they're at fault," says Ianelli. "We make sure to develop a case on why we should get paid. Sometimes, quite frankly, we have to fall on the sword and tell them that there was an error, but we want to get paid anyway. They may say no, but it does happen."

What falls through the cracks

With the large volume of cases handled by the department, it's inevitable that something will fall through the cracks occasionally. "A new staff member may miss the secondary payer, for example, or a coordination-of-benefit issue will happen from time to time," he says. "But as long as somebody is committed to being error-free, I think everything falls into place."

Ianelli says when he first joined the organization, he needed to make a decision about the direction the department was going to go in. "We made a strategic decision to have some turnover to get the people in who could do what we needed them to do," he says.

Ianelli adds that unlike many patient access departments, his doesn't have issues with morale or turnover — something he attributes, in part, to the team model and supportive environment he fosters. "In terms of financial staff, we have a nice long period of stability for, I'd say, about three years," he says. "If people are leaving, they tend to want to stay in the industry and go to nursing school. We do have somebody right now who will go part-time and still work."

The department has not had to face budget or staffing cuts, reports Ianelli. "We are really lucky so far," he says. "We report right up through the CFO, and she has a good sense of what is needed down here. And, on the flip side, if she does ask a department to cut its budget, she makes sure that her departments are cut equally."

Lean team

Over the past seven years, volume has grown significantly at the organization, but Ianelli only has asked for one additional FTE. "We don't just try to throw bodies at a problem — we run pretty lean here in the financial counseling and insurance groups," he says.

Success, whether with obtaining 100% authorizations or improving registration accuracy, "all starts with the interview," says Ianelli. "If you don't get good people in, everybody's going to end up miserable," he predicts. "Early in my career, I really hired badly, and it's so much more work. If you don't set the limit and get rid of people who aren't showing up and doing a good job,

CNE objectives

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■

COMING IN FUTURE MONTHS

- ■ Prepare your department for an RAC audit
- ■ Improving medical necessity compliance
- ■ The latest reimbursement changes from CMS
- ■ Extending case management beyond the hospital walls

then you're not doing your job as a manager."

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