HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

AHC Media LLC

IN THIS ISSUE

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Health care reform likely to penalize hospitals for readmissions

Start now to keep patients from coming back

Now that hospitals' 30-day readmission rates for heart failure, heart attack, and pneumonia are being posted on the Hospital Compare web site, the stage is set for the Centers for Medicare & Medicaid Services (CMS) to start reducing or eliminating payments for patients who are readmitted to the hospital.

"The president and Congress have both identified the reduction of readmissions as a target area for health reform. When we reduce readmissions, we improve the quality of care patients receive and cut health care costs," says U.S. Health and Human Services Secretary **Kathleen Sebelius**.

According to CMS, 19.9% of patients admitted to a hospital for heart attack treatment will return to the hospital within 30 days; 24.5% of patients admitted for heart failure will be readmitted within 30 days; and 18.2% of patients admitted for pneumonia are likely to return to the hospital within 30 days.

The Hospital Compare web site began reporting hospital readmission rates in July, listing whether a hospital's readmission rate is "better than," "no different from," or "worse than" the national rate.

Readmission rates are posted on the Hospital Compare web site only for hospitals that have treated at least 25 cases of a diagnosis during the reporting period.

The data exclude patients who have been readmitted to the hospital within 30 days of a discharge after heart attack when the readmission is for the purpose of a planned cardiac treatment, such as a heart bypass or a coronary angioplasty, as well as patients with any diagnosis who left the hospital against medical advice.

Factors such as availability of post-acute care services in the community and noncompliant patients can affect readmission rates but are not included in the risk-adjustment process.

"Readmission rates will help consumers identify those providers in the community who are furnishing high-value health care with the best results," says **Charlene Frizzera**, CMS acting administrator.

Proposals for penalizing hospitals for readmissions being considered in Congress and by CMS include bundled payment for hospitals and post-acute care services within 30 days, penalties for hospitals experiencing higher-than-average readmission rates, and making readmissions a "never event."

Whatever ultimately comes out of the current health care reform movement, hospitals are going to have to find ways to reduce readmissions because they're not going to get paid, says **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY, and health care consultant and partner in Case Management Concepts LLC.

What you can do to prevent readmissions

"Case managers are going to have to do a better job of assessing patients so they don't miss opportunities to provide post-acute services, follow-up care, and education that will keep patients from coming back to the hospital," she says.

A study in the *New England Journal of Medicine* showed that one-fifth (19.6%) of Medicare beneficiaries were rehospitalized within 30 days of discharge, at a cost of $17.4 billion.[1] The study concluded that the average stay of rehospitalized patients was 0.6 days longer than patients in the same diagnosis-related group whose most recent hospitalization had been at least six months previously.

"Readmission of a patient to a hospital after a short post-acute stay not only costs a great deal but also interrupts patients, continuity of care, and is disruptive to their families. However, it is a potentially avoidable event," says **Jackie Birmingham**, RN, MS, CMAC, vice president of professional services for Curaspan Health Group, a Newton, MA, health care technology and services firm.

Though not all readmissions are avoidable and not all avoidable readmissions are the fault of the hospital, hospitals still should share accountability for readmission rates that could be much lower, she adds.

Hospitals are going to have to rethink the long-standing paradigm that a full bed is better than an empty bed, Cesta says.

"Now there are so many reimbursement penalties for inappropriate admissions that were payable in the past. We are going to have to look at things differently and keep inappropriate patients out of the hospital," she adds.

The intent of CMS is to make readmission rates the captain of the improvement process for the new few years, says **Deborah Hale**, CCS, president of Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK.

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Editor: **Mary Booth Thomas**, (marybootht@aol.com).

Associate Publisher: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).

Director of Marketing: **Schandale Kornegay**.

Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@ahcmedia.com).

Senior Production Editor: **Nancy McCreary**.

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Editorial Questions

For questions or comments, call **Jill Robbins** at (404) 262-5557.

Medicare regulation published in the Medicare Claims Processing Manual, Chapter 3, Section 40.2.5 mandates that if a patient is readmitted due to inadequate or incomplete care during the first admission, the two admissions should be combined and paid as one DRG, Hale points out.

"This regulation is applied to all readmissions regardless of the time span between the two admissions. This has the effect of limiting reimbursement since the patient's second visit to the hospital will be part of the original DRG," she adds.

For patients readmitted within 24 hours of discharge, the hospital is expected to combine the two admissions and be reimbursed for one DRG unless the same-day readmission is completely unrelated to the first admission. In this scenario, the hospital may add Condition Code B4 to the claim for the second admission and be paid the DRG for both admissions, Hale says.

In recent years, many Fiscal Intermediaries or Medical Administrative Contractors have expected that all same-day readmissions be combined even without evaluation of the medical record to determine whether they are related, she adds.

Discharge planning part of UR process

Discharge planning must be a more aggressive part of the utilization management process, Hale says.

"Case managers play a major role in helping avoid readmissions. As they perform discharge planning, they should make sure the patients receive appropriate education on what to do after discharge so they don't come back because they didn't follow instructions. They should make sure the patients have the means to pay for their medications so they won't come back because they didn't get their prescriptions filled," she says.

More than half (50.2%) of the rehospitalized patients in the *New England Journal of Medicine* study had not seen a physician for follow-up between the time they were discharged and came back to the hospital.[1]

In addition, a MedPac study showed that 64% of patients readmitted within 30 days did not receive post-acute care, such as home health, between discharge and readmission, Cesta says.

Interventions that have been shown to reduce readmissions include better care during the hospitalization; more complete care plans; emphasis on coordination of care at the point of transition to home or post-acute care; better use of after-hospital care; and more involvement of the patient and caregivers in decision making, Birmingham says.

When the staff at Patient Response, a Milburn, OK, health care consulting firm, conduct audits of readmissions for client hospitals, they find exactly the same reasons for readmissions that have been cited in numerous studies, according to **Brenda Keeling**, RN, CPHQ, CPUR, president.

Many of the root causes of readmission were a failed discharge plan, she adds.

Patients who were readmitted didn't get their prescriptions refilled or understand how to take them. They failed to have a follow-up visit with a physician and/or didn't have the resources to buy food or medication. In some cases, the family didn't understand the discharge plan or failed to provide the care the patient needed. Some of the patients were discharged prematurely, Keeling says.

Sometimes the patients came in and were discharged the next day before the case manager got in to see them to determine their discharge needs, Keeling says.

"Everybody says they don't have these kinds of problems at their hospital, but every hospital we've audited did have these problems on at least one of the three diagnoses being tracked by CMS," she says.

CMs should access every patient

Forget the longstanding illusion that not every patient needs case management, Cesta advises.

"The days of picking and choosing who gets case management are over in today's health care environment. If hospitals are going to prevent readmission, case managers are going to have to assess every patient every day to make sure their discharge needs are met," she adds.

The practice of assessing a patient for post-acute needs on admission and never seeing the patient again has led to patients falling through the cracks, Cesta says.

"Patients can have setbacks during hospitalization and can leave the hospital much frailer than when they came in. Models where case managers don't see patients every day or they see only those for certain diagnoses or when there is a referral from a care provider have to be changed if we are going to prevent readmissions," she says.

The challenge is going to be convincing hospital management teams to increase the case management staff so that case managers can ensure the patients' discharge needs are met, Keeling adds.

In the past, when hospital administrators looked at case management effectiveness, they

looked at case mix index and length of stay and did not consider the discharge planning process, she points out.

"At some point, the administrative team will understand that they can't just keep giving case managers more and more to do. Hospital administrators must understand that when case managers have to wear too many hats, they simply can't do everything effectively. Case managers should have reasonable caseloads that allow them the time to complete all their duties, not just concentrate on commercial payers," she says.

*(For more information, contact: **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management, Lutheran Medical Center, e-mail: tcesta@lmcmc.com; **Brenda Keeling**, RN, CPHQ, CPUR, Patient Response, e-mail: brenda@patient-response.com; **Deborah Hale**, president, Administrative Consultant Services LLC, e-mail: dhale@acsteam.net; **Jackie Birmingham**, RN, MS, CMAC, vice president of professional services, Curaspan Health Group, e-mail: jbirmingham@curaspan.com.)*

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Analyze readmission rates to see why patients return

Use the information to improve your discharge plans

If hospitals are going to avoid penalties for 30-day readmissions, they need to start now to identify their own patterns of what caused the readmissions and use that information to improve the discharge plan, suggests **Jackie Birmingham**, RN, MS, CMAC, vice president of professional services for Curaspan Health Group, a Newton, MA, health care technology and services firm.

Start by reviewing every readmission to determine the most common DRGs and the most common reasons for readmission, adds **Brenda Keeling**, RN, CPHQ, CPUR, president of Patient Response, a Milburn, OK, health care consulting firm.

Talk to patients to get information about why they were readmitted. Gather the statistics and use them in the performance improvement process.

"It may be an issue with funding or the family may not have cared for them after discharge or the hospital may have discharged them prematurely," she says.

Analyze more than 30-day readmissions

In addition to reviewing the readmissions within 30 days, look further and analyze those who are readmitted within seven days or the same day, says **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY, and health care consultant and partner in Case Management Concepts LLC.

"If patients are readmitted 30 days after discharge, it's not as likely that the admission is related to their prior stay, but within seven days, it's more likely to be related," she says.

"If patients who are readmitted received post-acute care, drill down to determine what happened during the previous level of care," says Birmingham.

Look at patients who are readmitted after receiving home health services. Did the home health agency discharge them too soon?

"If case managers see a pattern in readmissions of patients receiving services from a particular home health agency, they should meet with them and make sure that the patients being referred to the agency are appropriate for what the agency can provide," she says.

Look at patients who are nonadherent and look for the reasons why.

Was it that they didn't understand the medications? Did they take an over-the-counter medication that made their prescription drug ineffective? Did they have multiple doctors who prescribed the same medication? Did the home health agency discharge the patient prematurely?

Since studies have shown that one cause of readmissions is lack of follow-up, case managers should make sure that patients have an appointment to see their doctor for follow-up within seven days of discharge and should make sure they understand the importance of keeping the appointment, Cesta says.

The challenge is ensuring that these patients get a follow-up visit, Cesta points out. In the case of patients who go to a hospital clinic, it is virtually impossible to get an appointment within a seven-day time frame, she adds.

Make a follow-up phone call shortly after

discharge to make sure the patient is taking his or her medication, has a doctor's appointment, and is not having problems, she says.

Many patients, particularly those with serious conditions, can benefit from one home health visit during the first days after discharge to help with the transition from hospital to home, Cesta adds.

"Another weak link in discharge planning is the educational piece. So many times, case managers simply do not have the time to make sure the patient and the family understand the discharge instructions," Cesta says.

Nurses, social workers, and others who are involved in coordinating the post-acute care of patients should be accessible to patients and family members and get their input on discharge plans, Birmingham says.

At the time of discharge, give patients specific prompts for what they need to do if certain symptoms occur, and follow up with them 24 hours after discharge, she says.

Some organizations have a program in place that supports follow-up with patients 24 hours after discharge, she says, adding that the program must be organized through the quality improvement process.

"There is no such thing as a simple follow-up call. The case manager needs to track the volume and issues raised during the calls and be able to help direct patients to appropriate resources, such as their physician, and hopefully avoid the advice of returning to the emergency department," Birmingham says.

Make sure that post-acute providers receive timely and complete information on patients in order to assure that they can provide the post-acute care the patient needs and to provide continuity of care once the patient is admitted to their organization, she adds.

Case managers need to make it a habit to use the discharge screens in the hospital's level-of-care criteria set to ensure that patients are stable enough for discharge and can be appropriately treated in an alternative setting, Keeling says.

"When case managers are looking for continuing medical necessity, they may not be consistently comparing the discharge screens to the patient treatment plan," she says.

Many patients don't meet discharge criteria at the time they are discharged because the case managers don't assess the discharge screen to make sure they are stable, Keeling says.

"Case managers are under pressure to aggressively move patients out of acute care as quickly as possible, based on the DRG length of stay. Because of this pressure, the patients may not meet the discharge screens for discharge," she says.

Hospitals should explore establishing a community case management program to coordinate care for high-risk patients and help them navigate the complex health care system after discharge, Cesta suggests.

"Some patients are simply lost when they leave the hospital. They don't see the doctor for follow-up. They aren't taking their medication because they didn't get the prescription filled or they get confused about what to take. They don't get their home care appointments and don't let anybody know," she says.

Then the patients show up in the emergency department where they are likely to be admitted because the emergency department doctor doesn't have any other options at 3 a.m., Cesta says.

"Community case management programs for high-risk patients can help hospitals meet their goals of reducing emergency department visits and readmissions by helping the patients follow their treatment plan and stay out of the hospital," she says. ■

Proactive approach results in lower readmission rates

HF task force focuses on four key initiatives

When the Centers for Medicare & Medicaid Services (CMS) analyzed hospital readmission rates to post them on the Hospital Compare web site, the lowest heart failure readmission rate in the nation was at the Baylor Jack and Jane Hamilton Heart and Vascular Hospital.

That's because Baylor Healthcare has taken a proactive approach to hospital readmissions, establishing systemwide task forces to develop initiatives for reducing heart failure 30-day mortality and readmissions at all hospitals in the system, says **Pam Stafford**, RN, BSN, CPHQ, health care improvement process consultant for the Baylor Healthcare System with headquarters in Dallas.

"Heart failure patients have the highest readmission rate of any diagnosis. We are concentrating on heart failure first, but the whole model can be translated to chronic disease management," she says.

The Baylor leadership team assembled a heart failure mortality and readmissions task force several years ago. The team started with a 12-item action plan and honed it down to four key items last year, according to Stafford, who took over the heart failure task force in May 2008.

The measures to eliminate heart failure mortality and readmissions as determined by the task force include using a standardized heart failure order set systemwide; improving medication reconciliation; improving continuity of care from inpatient to the post-acute setting; and focusing on end-of-life or palliative care and advance directives.

"Research does not show that one individual aspect of care keeps patients from being readmitted. We must pay attention to the entire continuum of care to improve the chronic care model. There are a multitude of appropriate interventions, so careful coordination is the key in caring for patients with chronic illness," Stafford says.

Systemwide order set

The Baylor health system instituted a systemwide order set for heart failure in December 2007. The order set includes evidence-based standards of care for heart failure, interventions from the Institute for Healthcare Improvement's 5 Million Lives campaign, and heart failure core measures.

The health care improvement department tracks the usage of the order sets and provides data every month to show outcomes related to when the order set is used vs. when it's not used.

"Our goal is to use the order set 80% systemwide. We're now in the 70th percentile on a monthly basis. We are nearing that goal," Stafford says.

"The use of facility-specific and system physician champions in the heart failure initiatives, as well as the use of the order set, is one of the key strategies to improve heart failure care," she adds.

If a particular physician isn't using the order set, the heart failure physician champion at that facility intervenes and conducts individual education to improve the use.

The care coordinators and staff nurses identify patients being admitted with heart failure and make sure the heart failure order set is on the chart.

Heart failure offers one of the greatest opportunities for medication reconciliation and education, Stafford points out.

"These patients are often on many medications and may be confused about how to take them properly. Although there is not just one intervention that decreases readmission, ensuring the patient has his or her medications and understands how to take them is very important," she says.

At Baylor, medication reconciliation starts in the emergency department, where the admitting physician is responsible for reviewing the medications on admission. When a patient is transferred from one unit to another, the pharmacy department sends a list of current medications so the physician can check off which ones to continue.

At discharge, the physician and the discharge nurse are both responsible for reviewing the medication list and explaining it to the patients.

At Baylor, the staff nurses are responsible for patient education and use a standardized array of patient education tools, including packets of information and videos on the hospital's television channel.

"The teach-back model for patient education confirms that the patient understands the inpatient and discharge instructions. Rather than just giving them information to read, we ask them to repeat or explain it to us to ensure we know they understand. This technique is more effective than just giving them a booklet or folder of information," she says.

Another strategy is to give the patient a contact person's telephone number, such as the number of the nurse manager on the unit from which he or she was discharged.

"We encourage them to call if they have any questions or are confused about their discharge instructions," she says.

When it comes to setting up post-discharge appointments, the patient often is the roadblock when the staff try to facilitate a follow-up appointment, Stafford says.

"Many times patients want to speak to their family members to schedule an appointment at a time when the family member can provide transportation. It's very difficult to set up an appointment that is acceptable to the patient before he or she is discharged," she says.

Recognizing that it's often difficult for patients to get a follow-up appointment in a timely manner, the heart failure team at Baylor Medical Center in Garland, TX, has arranged with a large physician group, Health Texas Physician Network, to work in appointments for heart failure patients within three to five days of discharge.

"The handoff and that connection are really important," Stafford says.

Another strategy used by the Baylor Health Care

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CRITICAL PATH NETWORK™

Electronic CM system optimizes data, patient flow

Software, data reports are standardized throughout the region

Sutter Health's Sacramento Sierra Region's customized electronic case management system with embedded InterQual criteria enables the case management department to track everything from individual case manager performance to regional outcomes.

The computerized case management system is an integral part of the hospital system's quality improvement process and includes quality and risk measures, publicly reported metrics, safety measures, adverse event reports, and other measures of physician and case manager performance, says **Michael Avriette**, utilization management executive for the seven-hospital region of Sutter Health, with headquarters in Sacramento, CA.

The Sacramento Sierra Region includes hospitals ranging in size from rural hospitals with 20 beds to larger metropolitan ones. All of the directors or managers of case management at the seven campuses report to Avriette. The information technology staff who support the software system are part of Avriette's department.

At one time, many of the hospitals in the region were using individualized versions of the software, Avriette says.

"We knew we had to create a standardized software system so we could measure apples to apples across the region," he says.

A team of case management representatives from all the hospitals in the region worked to standardize and integrate the case management software and processes.

"Together, we have standardized the data definitions, the software, and the reports. The reporting is the same at all the hospitals. We also use the same software for reporting on our dashboard," Avriette says.

All of the documentation, discharge planning, utilization review data, and insurance information is integrated, he adds.

Avriette uses the software system to create reports showing everything from meeting utilization review goals to the percentage of stays longer than 10 days and sends a monthly scorecard to the vice president of medical affairs, managers and directors of case management at all hospitals, the hospitalist groups, every case manager and social worker, and the hospital system's regional CFO.

"The information on those reports is part of our performance evaluation for the system as a whole, for each director, and each individual case manager and social worker. It enables us to identify when things are working and when they are not. We see how we are doing on a monthly basis so there are no surprises at the end of the year," he says.

At Sutter, when case managers log on to their computers, they pull up a work list that is populated with information about the patients they need to see that day, including admission reviews and continuing stay reviews.

If the case manager previously missed a field when conducting an insurance review, it is included on the work list.

The case managers review patients to make sure they meet InterQual criteria and fill out severity of illness and intensity of service check boxes.

"The documentation is all done electronically. The case managers use mobile laptops and a web-based program so they can complete their documentation wherever they are," he says.

When a patient doesn't meet acute care criteria, if there is a medical necessity issue, the software

automatically forwards the information to the physician advisor.

If there are issues, such as delays in service, the case automatically goes onto a work list for the case management director or manager to review.

The hospital system has created a case management intensive course that the staff development manager used to educate the staff when the software system was rolled out and now uses to train new staff.

New case managers go through an intensive two-day course and three days of shadowing. Then they work with a preceptor for six months.

"At the end of the week, they know how to access the software and perform the basic case management tasks. Then they can call the preceptor at their site for help," Avriette says.

The hospital's case management software and discharge planning software are integrated so that when the case manager has completed the discharge plan, all of the information is easily transmitted to post-acute referral sources.

"We use the software to track how often the referral sources say yes and how long it takes to get a referral," Avriette says.

"Retrospectively, I can look at the data and see how many referrals we sent to specific providers, how many times they accepted the referral, and how many times they said no and determine a pattern. For instance, we can tell if a vendor is cherry picking only patients with good payers," he says.

Using the automated software system helps the hospital comply with Medicare's patient self-determination requirements, he says.

The software has a prompt embedded in the discharge planning portion that asks the case manager to check off that the patient was informed of his or her right to choose a post-acute provider and was given a list of providers.

At Sutter Health, directors and managers of case management and individual case managers have individual goals that are aligned with each hospital's goals and systemwide goals.

For instance, case managers are responsible for case management, utilization review, and discharge planning and have a goal of assessing all patients within 24 hours of admission.

The case management software system automatically creates reports that measure how well the goal is being met by hospital, service line, and individual case manager.

"We have integrated managerial reports so a manager can see at any given point whether the individual case managers are meeting their goals," Avriette says.

The hospital system uses the software to track everything from service delays to medical necessity issues referred to the physician advisor.

"I can generate reports by case manager or by physician advisor and monitor quality by identifying patterns. I can easily generate a report showing how many patients didn't meet InterQual criteria, how many cases were referred to the physician advisor, and whether they were upheld or overturned," Avriette says.

He uses the data to identify practice patterns among individual physicians and provides information to the hospitalist groups at each hospital on which physicians are admitting patients who don't meet criteria or who have not discharged patients and how they compare to their peers at other hospitals.

For instance, Avriette can determine how physician advisors compare with their peers at other hospitals when it comes to approving admissions that don't meet InterQual criteria.

Avriette uses the software to track length of stay and the percentage of patients who don't meet continued stay criteria.

"We can look at this by hospital or by individual physician. If one hospital has a higher rate of patients who don't meet continued stay criteria, we can look at physician practice patterns and intervene if necessary," he says.

Avriette uses the data he receives to identify educational opportunities for the entire case management staff.

For instance, the hospital region has conducted educational sessions on the appropriate use of InterQual's "Guidelines for Surgery and Procedures in the Inpatient Setting," also known as the "inpatient list."

"These guidelines are confusing because some subsections of a procedure will qualify for an inpatient admission and some will not," Avriette points out.

For instance, pacemaker insertions do not qualify for an inpatient admission unless they are urgent or inserted by thoracotomy, he says.

"We determined that people were not using these guidelines properly, so we've conducted a lot of education on this issue," he says.

*(For more information, contact **Michael Avriette**, utilization management executive, Sacramento Sierra Region, Sutter Health. E-mail: avrietm@sutterhealth.org.)* ■

Review of one-day stays improves documentation

Supervisors look for opportunities for improvement

At Sutter Health's Sacramento (CA) Sierra Region, case manager supervisors at each hospital conduct a secondary, retrospective review of 100% of one-day stays of Medicare patients to ensure that the individual case managers are making the right determination and using any deficits they uncover as an educational opportunity.

The system has significantly improved the accuracy of the case managers' reviews, says **Michael Avriette**, utilization management executive for the seven-hospital region of Sutter Health, with headquarters in Sacramento.

"We concentrate on one-day stays because they are the most at risk for not meeting medical necessity criteria. In addition, we don't have that many and they are easy to track," he says.

In addition, the review of one-day stays gives the case management supervisor a good indication of how accurate the case manager is likely to be on other cases, he adds. "If people know that a particular kind of case is going to be reviewed and they still have a lower-than-average accuracy rate than their peers, it's probable that their accuracy is lower than average on other cases, as well, and that they need additional education on medical necessity criteria," Avriette says.

Each hospital's software system automatically populates a work list of one-day stays of Medicare patients for the case management manager to review each day.

The manager reviews the case manager's documentation in the software and, if necessary, reviews the medical records as well to determine if the case manager made the right decision.

"If the manager finds that a one-day stay doesn't meet admission criteria, he or she looks at where the opportunity for improvement occurs and determines if it is an educational opportunity or a performance management opportunity," Avriette says.

The manager then works with the individual case managers to educate them on why the patient should not have been admitted for inpatient care.

An example of a performance management improvement is if a case manager qualifies the inpatient admission of a patient with dyspnea when his oxygen saturation is 90%. InterQual criteria specify that in order for dyspnea patients to meet acute care criteria, their oxygen saturation has to be less than 89%. "Sometimes case managers feel pressured not to have a conversation with a doctor about admitting a patient. In this case, if the oxygen saturation was 90%, the case manager might fudge and let the admission go unchallenged but the patient clearly doesn't meet admission criteria. The director educates them that they have to follow criteria," he says.

An example of an educational opportunity might occur if a case manager qualifies an inpatient admission for a patient with syncope and hypertension. "Patients with syncope qualify for an inpatient stay if they have a cardiac disease, and it's debatable as to whether hypertension would count. This would be an honest mistake," Avriette says.

The case management director checks off if the review showed that the case manager made the right call. If the stay was not appropriate, then he or she documents the action taken.

The results of the reviews of one-day stays go into the system in which Avriette generates monthly reports to determine how accurate each hospital's case managers are. ■

Multidisciplinary meetings lower LOS, excess days

Mandatory meetings involve all disciplines

Within 45 days after daily multidisciplinary patient care conferences were instituted at North Fulton Regional Hospital, the hospital's average length of stay dropped by more than a day and excess days decreased by more than 300 days within the first quarter of implementation.

The initiative has increased the hospital's compliance with core measures and allowed the case management department to better identify and track patients in observation status, says **Kamela Sooknanan**, RN, administrator of clinical quality improvement and case management services for the 202-bed hospital in Roswell, GA.

"The greatest asset to impacting quality of care has been the early identification of the need to involve additional disciplines in the patient's care and assigning accountability for meeting the patient's needs. All of the disciplines are there from the get-go to share information about the patients," she says.

Staff members make up for the time they spend

attending the morning meetings later in the day because they don't have to track down individual disciplines for questions, Sooknanan adds.

When the hospital began the conferences in August 2006, Tenet Healthcare had begun a corporatewide initiative to have all the hospitals in the system implement daily patient care conferences to manage length of stay and improve overall patient outcomes.

"As case managers, we know how significant the multidisciplinary approach is to managing and coordinating patient care. In addition, at the time of the corporate roll out, our length of stay had been trending up. Therefore, this was the perfect opportunity to institute a daily care conference approach and meet both needs at once," Sooknanan says.

At the time, the hospital was holding weekly patient care conferences on the units, but they were poorly attended. The charge nurse presented the cases, and the team focused on the discharge plan and information sharing.

"The meeting structures were lacking in the care plan development process. Many people thought of them as being case management meetings and they just didn't attend," Sooknanan explains.

Now, the directors of every department make sure their staff attend the meetings, and directors also attend the meetings.

When the mandatory meetings were instituted, many staff members complained about the time commitment and competing priorities.

Hospital management created a policy for daily patient care conferences, and the management team continually showed its support for the conferences.

For several months before the conferences were implemented, the team conducted focused housewide education, putting up posters on all the nursing units and introducing the concept of nursing and ancillary staff meetings. All directors received weekly e-mail updates. One-on-one education was conducted with key physician groups, and newsletters were sent to the entire medical staff.

The support of the hospital's leadership team was instrumental in getting the meetings off the ground, Sooknanan says.

"We let everyone know that these meetings were necessary to improve quality of care and length of stay. The way we approached it is that nobody gets a pass for not coming to the meetings on any day. It's ingrained as part of our operations," says **Ilona Wozniak,** chief operating officer.

In the beginning, Wozniak or someone else from senior management attended the daily meetings.

"This reinforced the expectation that we would see all of the multidisciplinary team members and directors at the meetings. If someone wasn't present, we would follow up with his or her supervisor. Directors are kept informed, and they know that a team is committed to this project and that it is mandatory for everybody to participate," she says.

Disciplines attending the meeting include case management; nursing; hospitalists on the medical units; physical, occupational, and speech therapy; pharmacy; respiratory therapy; nutrition; unit directors; ancillary directors; and the director of case management.

The meetings are held in the mornings at staggered times so that no two units are meeting at the same time, allowing staff who cover multiple areas to participate. Each meeting covers 20-30 patients.

The team discusses every new admission on the morning after admission and discusses every patient with a length of stay of four days or longer.

"Each patient is discussed each day with the exception of Day 3 of their admission. Many patients are discharged on Day 3 of their hospital stay," Sooknanan says.

The meetings are very formal and have strict ground rules, which include no side conversations, and are redirected as needed to keep the focus on the patients and the issues affecting the progression of care.

The team is committed to starting and ending the meetings on time and limiting the time to 30 minutes, Sooknanan adds.

"Whenever a case is complex, we off-line it and the people most closely involved finish the conversation after the meeting," she says.

For instance, if a patient has significant social issues, instead of spending time at the meeting coming up with solutions, the case manager would consult with the other team members after the meeting.

The case managers lead the meeting. They introduce the patients and the diagnosis and turn it over to the nurse to present the patient's clinical status.

The team focuses on what is keeping the patient in the hospital and potential barriers to discharge. These include diagnosis and current status, home/social situation, invasive devices, respiratory status, physical therapy and occupational therapy needs, diet and intake, wound care, and pertinent tests and procedures and tests that are pending.

(For more information, contact: ***Kamela Sooknanan****, RN, administrator of clinical quality improvement and case management, North Fulton Regional Hospital, e-mail: Kamela.Sooknanan@tenethealth.com.)* ■

(Continued from page 134)

System is a process whereby care coordinators identify patients at high risk for readmission and hold daily huddles to discuss the patients' discharge planning with a member of the nursing staff and social workers. The process includes post-discharge phone calls to make sure the patients have follow-up appointments and to discuss symptoms and medication.

"The process is not widespread because of the resources needed to conduct the phone calls properly. Understandably, when the inpatient staff discharge their patient, their eyes turn to the next patient in that bed. In health care, we all are going to have to realize that we are responsible for the patient's transition in care," she says.

The hospital system is piloting a transitional care model developed by Mary Naylor, PhD, RN, at the University of Pennsylvania School of Nursing that uses advanced practice nurses to coordinate care after discharge.

"The nurses see the patients in the hospital and develop a relationship with the patients and their physician, then coordinate the care as the patient leaves the hospital. They see the patients in their homes within 24 hours of discharge and accompany them to the first physician appointment," she says.

During the pilot, which began at Baylor Medical Center in Garland in August, the advanced practice nurses will follow the patient for up to three months.

"The nurses will help facilitate chronic care management and act as an advocate to keep the patients on track and help manage their symptoms. This new model should improve all our outcomes, including 30-day mortality and readmission rates," Stafford says.

Baylor has assembled palliative care teams at each hospital so the physicians can call on them to talk with the patient and families about end-of-life issues and hospice care.

"Physicians typically are not comfortable with broaching the subject of end of life with their patients," Stafford says.

One of the smaller community hospitals in the Baylor system had a high mortality and readmission rate for heart failure. The hospital looked for causes and determined that one reason was that the nursing homes in the area were transferring patients to the hospital to die.

The team at that hospital worked closely with the nursing homes to institute appropriate palliative care or hospice for patients with end-stage heart failure. The initiative improved the quality of life for the patients and kept them out of the hospital. ■

CMS changes wording of orders for observation

Make sure documentation reflects new language

In an effort to clarify what had been confusing in the past, the Centers for Medicare & Medicaid Services (CMS) changed the wording of the observation orders and admission status, effective July 1.

Now instead of using the term "place observation status" or admit to observation," the physician order should read "outpatient — refer for observation services."

Transmittal 1760, issued June 23, 2009, didn't change the appropriate use of observation status, but it did change the language by which physicians order these services, says **Deborah Hale**, CCS, president of Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK.

"There is no payment status called 'observation.' Observation care is an outpatient service, ordered by a physician and reported with a HCPCS [Healthcare Common Procedure Coding System] code," CMS wrote in the transmittal, which updates the Claims Processing Manual.

Case managers should educate physicians about the revised wording of their order and work with the medical staff to achieve standardization.

"When this wording is included as an option on standardized order sets or computerized physician order entry, the facility is more likely to get it right all the time," Hale says.

Case managers should make sure that documentation for patients receiving observation services states "referred for observation services," she says.

This may mean that hospitals need to change their standing orders to reflect the language now required by CMS, Hale adds.

It's important to make sure the language is correct so that the Medicare Administrative Contractors (MAC) or Recovery Audit Contractors (RACs) will be able to determine the physician's intended level of care and avoid inappropriate claims that result when a physician's order is worded "admit for

observation," she says.

In the transmittal, CMS emphasizes that in no case may a nonphysician make a final determination that a patient's stay is not medically necessary or appropriate, Hale says.

"The transmittal made it clear that case managers cannot change a physician's order for inpatient admission or take sole responsibility for determining the patient's level of care. Only a physician can change a patient from inpatient status to observation services," she adds.

"This instruction, first published in 2004, references a change from inpatient status to outpatient. Observation may not be billed for the time a patient was thought to be an inpatient, as this service is billable only when a physician has ordered observation services," she says.

Even though Transmittal 1760 makes reference to "admission protocols: These reminders about physicians' responsibility for the level-of-care order is evidence that CMS is not referring to a case management protocol in which the case manager is solely responsible for assigning a level of care," Hale adds.

On April 22, 2009, National Government Services[1] posted an opinion regarding the use of a case management protocol to determine level of care, Hale says. The following statement was included:

"Many facilities are attempting to implement a 'standing order' practice that removes the physician from the decision-making process, and to date, CMS has given no indication that this practice is acceptable. If these protocols are used, then the inpatient admission is not recognized until the physician (nonphysician practitioner) responsible for the patient's care concurs."

However, CMS states that it expects hospitals to employ case management staff to facilitate the application of hospital admission protocols and criteria, and to facilitate communication between practitioners and the utilization review committee or Quality Improvement Organization.

CMS allows the use of Condition Code 44 to address late-night or weekend admissions when no case manager is on duty to offer guidance but emphasizes that it is to be used sparingly.

"Use of Condition Code 44 is not intended to serve as a substitute for adequate staff or utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols," the transmittal says.

Hospital Conditions of Participation require all hospitals to have a utilization review committee with at least two physician members who review admissions for appropriateness of the level of care. Review of admissions may take place before, at, or after a hospital admission.

In order for hospitals to file a Condition Code 44 claim, the medical record must have documentation of a physician's concurrence that an inpatient admission is not medically necessary and that the patient should have been registered as an outpatient. The reason for the change and those involved in the review should be documented as well.

The practitioner responsible for the care of the patient must be consulted and allowed to present his or her views before the utilization review committee.

"To achieve success with level-of-care determinations, hospitals are going to need to change the practice of having case managers review a patient's chart for medical necessity 24 hours or more after admission. The patients are going to have to be screened before or at the time of admission in order to facilitate appropriate level of care, even if that includes a referral to a physician advisor at the time the decision is made," Hale says.

(Editor's note: This article includes the most recent information from the Centers for Medicare & Medicaid Services as of July 31 and may be subject to change.)

Reference

1. National Government Services is one of the largest Medicare contractors in the country and has served as a Medicare contractor since 1966. ■

AMBULATORY CARE
QUARTERLY

Complications in chest pain patients in crowded EDs

Symptoms of 'dysfunctional hospital'

Patients with heart attacks and other forms of chest pain are three to five times more likely to experience serious complications after hospital

admission when they are treated in a crowded ED, according to a new study published online in the journal *Academic Emergency Medicine*.[1]

The study followed 4,574 patients who were admitted to the Hospital of the University of Pennsylvania in Philadelphia for symptoms of chest pain over an eight-year period. Ultimately, 802 were diagnosed with an acute coronary syndrome; of those, 273 had a true heart attack. There were 251 complications that occurred in the hospital after initial ED treatment. Complications included serious events, such as heart failure, delayed heart attacks, dangerously low blood pressure, heart arrhythmias, and cardiac arrest.

When the ED was at its highest occupancy and waiting room census, patients with acute coronary syndrome (ACS) were three times more likely to experience complications in the hospital. When the patient hours were highest, they were more than five times more likely to have a complication. "Most of these complications occurred long after the patients left the ED, but while they were still in the hospital," notes **Jesse M. Pines**, MD, MBA, MSCE, assistant professor of emergency medicine and epidemiology at the hospital and lead author of the paper.

The authors noted that these complications were not explained by what is or is not happening in the ED in terms of specific treatments and timing, such as giving patients aspirin or a timely EKG. Instead, they said, it pointed to a "dysfunctional" hospital.

Jim Horn, MD, FACEP, medical director of the ED at Mercy Hospital Fairfield (OH), says, "One thing I take away from this study is that expected basic quality care measures were received. I don't know if this is a marker of a 'dysfunctional' hospital, but when patients are at their sickest, you potentially see a higher rate of complications, and when the ED is at its highest capacity, you often see patients with higher acuity."

Nevertheless, the authors noted, the findings underscore the need for action on the part of hospital administrators, policy-makers, and emergency physicians.

What can ED managers do to minimize these "downstream" complications? "Patients have to be seen quickly and diagnosed appropriately," Pines says. "There must be a good review of their old medical records; and the medications the patient is currently on have to be put into the system. Once the patient is to be admitted, the inpatient team has to come down, and there has to be a smooth transition of care from the ED team."

Horn says, "I agree these are all things that we strive for."

Still, says Pines, a different approach must be taken in light of the study's findings. "ED managers need to realize that these particular patients are at higher risk," he says. "They must communicate with their physicians that during crowded

CNE *questions*

9. According to CMS, what percentage of heart failure patients are likely to be readmitted within 30 days of discharge?
A. 18.2%
B. 19.9%
C. 24.5%
D. 27.3%

10. According to a study in the *New England Journal of Medicine*, what percentage of patients rehospitalized within 30 days of discharge had not seen a physician for follow-up.
A. 50.2%
B. 64%
C. 19.9%
D. 32.5%

11. In addition to reviewing the readmissions within 30 days, look further and analyze those who are readmitted within seven days or the same day, says Toni Cesta, PhD, RN, FAAN.
A. True
B. False

12. The Baylor Health Care heart failure team started with a 12-item action plan to reduce heart failure readmissions and honed it down to how many items?
A. Eight
B. Five
C. Four
D. Three

Answer key: 9. C; 10. A; 11. A; 12. C.

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 **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

times, even though it is very easy to focus on only the most critically ill patients, those with chest pain are at higher risk for having complications when the ED is crowded — regardless of whether or not they have ACS [acute coronary syndrome]." Thus, Pines says, at these times there must be an even greater focus on the different processes of emergency care.

Horn says, "We're always concerned when volume is high, but our goal is still to see every patient quickly and diagnose them appropriately but quickly. In my place, the [chest pain] patient gets an EKG as soon as he hits the door."

Reference

1. Pines JM, Pollack CV Jr., Diercks DB, et al. The association between emergency department crowding and adverse cardiovascular outcomes in patients with chest pain. *Acad Emerg Med* 2009; June 22. Epub ahead of print. Doi: 10.1111/j.1553-2712.2009.00456.x. ■

Education reduces peds asthma readmits

Experts say programs can be provided by ED

The medical literature shows that educating children and their parents about asthma can reduce return visits to the ED as well as hospital admissions, and experts say the ED may well be the best place to provide that education.

The Cochrane Library, a London-based publication of The Cochrane Collaboration, an international organization that evaluates health care research, recently reviewed 38 randomized controlled trials involving 7,843 children.[1] The authors concluded that educational interventions were effective in reducing the risk of subsequent ED visits by just more than 25% and that educational intervention also resulted in fewer unscheduled doctor visits.

"I think it's great that there is evidence to support this," says **Joseph Zorc**, MD, an associate professor of pediatrics and emergency medicine and attending physician at The Children's Hospital of Philadelphia. "So many patients come to the ED with their asthma not well managed."

Vincent Wang, MD, associate director of the division of emergency and transport medicine at Children's Hospital of Los Angeles, agrees. Wang adds that the need is even greater today because primary care physicians simply don't have as much time as they did formerly for educating their patient.

Wang and Zorc agree that a one-size-fits-all approach to education will not work. Wang says, "It needs to be customized. There can be some generalization, but every patient has different needs." So, for example, common issues such as causes of asthma and asthma triggers could be made into a single education module, but medications, individual exacerbations, and the method used to teach the patient and the family must be customized. "Basically, when patients come to the ED, they are in different stages of their disease, as is true with any chronic disease," adds Zorc. "They also have different levels of understanding. Many times younger children are just learning, or their parents may just be coming to grips with the fact that their child needs regular preventive medicine. Not everyone is comfortable with that."

The best way to determine those specific needs is to assess the family, he says. How do you make that assessment? "You do it the same way a lot of great clinicians have always done," Zorc says. "You talk to the family and ask a few questions about what they're doing and what they think their child's needs are."

Zorc and Wang provided asthma education in their EDs; in fact, Zorc's department has an entire section devoted to asthma treatment. There are six rooms reserved for asthma patients, and they are staffed by respiratory therapists (RTs) and nurse practitioners (NPs). The department also has an observation unit where kids can go for 12-24 hours.

"This is a team approach," Zorc explains. "The RTs spend time with the family, especially focusing on devices and inhalers. The NPs handle the assessments and education."

Wang's facility has an asthma action plan — a packet of general information about asthma and specific care the patient has received. Every packet has several common components, and the rest is filled out by the provider based on what the patient requires for immediate care and in the future.

Reference

1. Haby MM, Waters E, Robertson CF, et al. Interventions for educating children who are at risk for asthma-related emergency department attendance. *Cochrane Database Syst Rev* 2009; Issue 1. Art. No.: CD001290. Doi: 10.1002/14651858.CD001290. ■

D-to-D slashed 85% — in seven weeks!

ED manager, consultant, CEO a powerful team

The ED at Twin County Regional Hospital in Galax, VA, succeeded in cutting its door-to-doc time from 121 minutes to 19 minutes in just seven weeks — while annual volume was climbing from 19,000 to about 30,000 — by combining a process improvement plan designed by a health care consulting firm, the leadership of the hospital CEO, and the ED's medical director. The plan, which totally eliminated the ED waiting room, was implemented by Ryerson Management Associates in Akron, OH.

The consulting firm's initial assessment, begun in January 2009, indicated specific areas of need. "We had our physician and nursing consultant come in and look at quality of care, and both said it was very good," recalls **Peter Ryerson**, MBA, president and CEO. "We looked at patient satisfaction and felt it could be better, and most of that is built on turnaround time."

In the new process, patients who present to the ED are met by a greeter (usually an RN). "They stand at eye level to the patient and greet them the way our parents taught us: 'Good morning. What brings you to Twin County Regional Hospital today?'" he says. "They do a quick registration and bring them back to a room." Available rooms are indicated on a tracking board.

Hugh Jenkins, MD, FACEP, the medical director, says, "As they walk down the hall, the greeter uses our radio system to tell the doctor and nurse assigned to that room that they have a patient, and they provide the primary complaint. By the time they get there, the nurse is usually there."

If the nurse assigned to the room is tied up, he adds, the greeter nurse will start triage. "At the same time we put a chart with the room number in the doctor's slot," Jenkins says. "A lot of times everyone will get there at the same time."

Several services are provided at the same time, via the trauma model of care, Jenkins says. "Basically, it is a team effort of coordination, where the patient is seen essentially simultaneously by the nurse and the doctor," he explains. "Sometimes the doctor will see the patient before the nurse, and sometimes the other way around, but the same services and documentation are completed by the end of the visit."

Patient satisfaction for the ED has improved from 74.7% in February 2009 to 81.7% in May 2009. The "true" current rating might be higher than that, argues Ryerson. "So many people have had poor experiences in the past, can still remember from what they experienced several visits ago, and may not rate the ED as it currently is," he explains.

The ED would not have succeeded in these efforts without a significant change in culture, not only in the department, but throughout the hospital, says Jenkins. While The Ryerson Group might have had its focus on the ED, the entire hospital had to be involved in making things happen.

In addition, notes Jenkins, there is a benefit in having an outside consultant involved in such cultural changes to "ride herd" on the staff. In fact, changes were made in every unit of the hospital, from room cleaning to lab and X-ray. "All those processes had to be examined.

Through this process, for example, admission was streamlined. "All patients must be on the floor within 30 minutes of the decision to admit," Jenkins says. "That's unheard of!"

This admission deadline was accomplished with

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

- Why emergency department case managers are so important
- One hospital's homegrown RAC appeals process
- Improving communication among the interdisciplinary team
- Opportunities for case managers during health care reform

the implementation of several changes, says Ryerson. "First, we set up a system to identify when the room was vacant," he says. "We designed a system to get housekeeping to the room and have it cleaned within 25 minutes, and we then faxed the ED orders to the floor and transported the patient to the floor without any phone calls from the ED."

The following improvements were accomplished within four months:

- Laboratory tests for patients in the ED are all below 30 minutes from request (order by physician) to result.
- Results from diagnostic radiology procedures usually are received in 15-20 minutes.
- The environmental services department maintains the ED, with a level of cleanliness of more than 95%.
- For treat-and-release patients, the average time for arrival to discharge time has decreased from two hours and 50 minutes to one hour and 39 minutes.

Jenkins notes that Ryerson was able to counter the natural skepticism of the staff. "Even if the CEO had gone down personally to the lab, it would not have been as good as Peter coming in and saying, 'I've done this 50 times before,'" he explains. "When a staff member says something can't be done, and he says he's already done it, it's very hard to have resistance." ■