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Kaiser/VA/DoD partnership piloting a nationwide EHR network

Early testing encouraging; improvements in quality anticipated

It appears that the federal government's vision of a nationwide health IT network is starting to become a reality, with the launch of a pilot program by the Department of Veterans Affairs and Kaiser Permanente — soon to be joined by the Department of Defense — that will allow the exchange of electronic health record information between VA and Kaiser providers (and soon the DoD as well) for veterans who receive care from both entities and agree to participate. The program utilizes the Nationwide Health Information Network created by the Department of Health and Human Services.

"The ability to share critical health information is essential to interoperability," said Secretary of Veterans Affairs **Eric K. Shinseki** in announcing the program. "Utilizing the NHIN's standards and network will allow organizations like VA and the Department of Defense to partner with private-sector health care providers to promote better, faster, and safer care for veterans."

The pilot program currently connects Kaiser Permanente HealthConnect and the VA's electronic health record system, VistA, two of the largest electronic health record systems in the country. The DoD's ALTA system will be linked to the other two shortly.

Prior to the launch of the pilot program, the VA and Kaiser

Key Points

- Sharing of relevant medical data can help prevent potentially deadly drug interactions.
- Storing all information in a single EHR network can be a big time-saver for providers.
- Using an outside vendor can help ensure objective measurement of outcomes.

Permanente sent a joint letter to veterans in the San Diego area who receive care from both institutions, to invite them to participate in the pilot program.

"We've had an excellent response rate to the invitation letters," says **John Mattison**, MD, chief medical information officer and assistant medical director for Kaiser Permanente. "We sent the letter to 1,200 veterans and received positive responses from well over 30% in the first week." Ultimately, he adds, the partners plan to have an ad hoc process to allow patients to opt in and sign up "right on the spot."

Patient privacy will be ensured, says Mattison. "We are using industry-leading standards for privacy and security throughout the course of this trial," he asserts. "There are industry standards in this space, and we use all of them. We've been through a very elaborate policy discussion to be sure to use every possible security element; we're not taking any shortcuts."

A logical partnership

Mattison says the partnership between these organizations makes a great deal of sense. "What makes these three organizations unique is that we have very large-scale operations and nationwide operations — and, in the case of the Department of Defense, international operations," he explains. "That puts us all in a relatively common position with respect to some of the health information exchange initiatives."

These initiatives were originally launched, he says, with the intention of helping Regional Health Information Organizations (RHIOs) produce mechanisms and policies for exchanging information. "That's great, and we support multiple regional and statewide exchanges, but what we can't afford to carry as overhead for our members is the cost of connecting to every proprietary system," Mattison says. "So, what we've endeavored to do for many years is have a single mechanism and policy framework, so whether the patient is in a small county in Georgia or a large one in California, the same mechanisms will be in place — and that same objective is very near and dear to the strategists at the Department of Defense and the VA."

Solving such a challenge on a small scale is difficult, says Mattison, and on a large scale it is even more difficult. "But we at KP and our counterparts felt it was so important to solve we put up our own money to blaze this trail for the country."

Test results 'encouraging'

Mattison says that prior to the pilot launch, some initial testing was conducted. "I'm excited that we had some very encouraging results with the testing and trial, which was with real patients," he says.

The test, conducted Sept. 30, 2009, involved a single patient in the VA and a single patient in a Kaiser Permanente clinic, both treated on the same day. "When the patient first came to the VA hospital the doctor interviewed him. He said, 'I see you've given permission for us to access information at Kaiser Permanente; may we do that now?'" Mattison shares. "With a single-click request, the doctor instantly retrieved all previ-

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ous conditions, medications, and allergies out of our system. At the end of the interview, a doctor on the Kaiser side was able to get an updated list from the VA on the same patient." On the same day, a Kaiser patient in San Diego "had an exactly symmetric situation."

The test, he adds, was observed via webinar by the Office of the National Coordinator of the Department of Health and Human Services, which handles health IT. "This is the largest-scale pilot using exactly what the government has prescribed," Mattison explains. "Their offices were intimately involved and engaged in discussions and the planning session."

The test, Mattison continues, demonstrated far more than technological wizardry. "The Kaiser Permanente patient had not been seen by us in a long time, but when we pulled up his VA records, we found two recently reported life-threatening allergies at the VA to extremely common medications," he says. "It would have been quite easy, in the absence of that information, for the KP physician to prescribe a different drug in the same class — one was an anti-hypertensive, the other a cholesterol-lowering drug. So, the doctor could have prescribed that other drug and the patient could have said he had no allergy to it. This is a powerful illustration that something as simple as the exchange of this information could be of immense clinical and patient safety benefit."

Quality is key

The goal of the program, first and foremost, is to improve the quality of patient care by having more comprehensive access to information, says Mattison. "In the past, when that vet came into the Kaiser Permanente clinic and said they had been seen at the VA a couple of months ago, what happened was if the doctor had them sign a release, and if the VA had the time, they would copy some records they thought we might be interested in and they would be sent to our medical records department," he notes. "Some doctor here would then sit at their desk and review the information; that whole process would take weeks to months. We've already shown that in less than a second that whole loop can be closed. This is a profound change."

Mattison continues: "What you don't know about a patient will hurt you in health care; from a physician's perspective it's unnerving to know there are other records somewhere you can't access."

He says the partners have engaged a third party to come in and perform objective measurement of all outcomes. "Because this is a pilot, we're trying to keep participation at a low level until we figure out how best to use it and harden the infrastructure," he explains. "We will evaluate every element and identify the best quality and safety indicators. We have a long list of metrics, and the initial work of this consultant will be to help us narrow them down."

The technological solution

While improved quality and safety are the ultimate goals, "the pilot itself really focused, in addition, on establishing the technical solution so that once we've established that this solution is rock solid, we can fairly easily roll it out to all of KP, the VA can do all of the VA, and the Department of Defense can do the same," says Mattison. "The power of this solution is the way we send and receive information over the wire is the same — the same protocols, the same standards. That is a very powerful demonstration of how when you use open standards programs they can be rolled out very quickly." In addition, he says, "Once we prove this works in one location, we know it will work in any location. We also know that anyone who chooses to join us can do so."

That's because the partners are using internationally accepted standards for how document exchange is handled. "It's not an accident that the pilot site is in San Diego, because the continuity of care document was co-founded here by myself and a good friend of mine 12 years ago, and now it is an international standard — part of the clinical document architecture," says Mattison. (This architecture now includes standards known as HL-7, CDA, and CCD.)

Thus, he continues, "The CDC [Centers for Disease Control and Prevention] is staged to be one of the participants in the future. Other smaller organizations in California have already stood up the same infrastructure; they want to join and will in due time." All that will be needed, he says, is for the participant to be able technologically to interface with the network and to sign a Data Use and Reciprocal Support Agreement.

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Nurses improve medication administration accuracy

Many solutions are simple, low-cost

A group of seven hospitals in the San Francisco Bay area participated in an 18-month-long program designed to improve the reliability of medication administration by deploying nurse leadership and PI skills on a single med/surg unit. The results? Among the six hospitals that were included in the first analysis, accuracy improved from 85% to 92% in the first six months and to 96% 18 months after the intervention. The study was published in the *Joint Commission Journal on Quality and Patient Safety*.[1]

The study involved the implementation of the Integrated Nurse Leadership Program (INLP), which provides frontline nurses and other hospital staff with training, resources, and authority to devise and implement solutions. In addition to showing the importance of empowering frontline nurses, the most significant finding of the study is that "significant improvement in outcomes can be accomplished without very expensive fixes," says **Julie Kliger**, MPA, BSN, RN, INLP creator and program director at the Center for the Health Professions, University of California, San Francisco; principal and founder of The Altos Group; and lead author of the article.

"That's important because there are a lot of financial and resource pressures today, and people sometimes think they need to spend millions for bar-coding; this demonstrates through almost old-fashioned QI and engaging the people who are doing the work and providing them with tools, skills, and resources, that they can make statistically significant improvement."

Key Points

- Frontline nurses often have good ideas, but are not empowered to express or implement them.
- QI solutions do not have to "break the bank" of your hospital.
- Ongoing monitoring is critical if you want to sustain the gains you achieve.

Empowerment is critical

Why is it critical to empower frontline nurses to obtain such results? "I think it's essential to empower frontline clinicians because they are the ones doing the work," Kliger explains. "They know, see, observe, and live the problems, and have often thought about how to correct them — but are not typically put in the position where they can exercise that knowledge. When you give them the time, the resources, some tools, and support to do that in an organized framework and they are able to take what they intuitively know and funnel it in a framework and apply it, you not only get the right answers and solutions, you also get engaged workers."

That's why the INLP model is successful, says Kliger. "It weaves together both the technical framework we like to see in PDSA [Plan, Do, Study, Act], and it engages anyone who is closest to the issue. Having been a frontline nurse and been on the management end, I know you have to do that. As a frontline nurse I always had opinions, but the organizations were not set up to help me fix the problem. This model weaves together the frame and reliability, knowledge, understanding, using data, along with whatever outcome you are trying to advance."

In addition, she says, it weaves in "softer" skills, such as effectively communicating the key message. "Things will change depending on who you speak with, how well you understand the dynamics, your organizational savvy, and learning how to reach your environment," Kliger explains.

Customize your solutions

There is no "one size fits all" solution to medication administration accuracy, Kliger emphasizes; your solution must be customized to your facility. "Customization is very important because each unit is in itself a microsystem — even within a facility," she explains. "Its culture, attitude, flow, processes — they all function quite differently."

This is not to say, she continues, that the outcome or patient indicator can vary, but the solution to get there has to be customized. "You can't say the ED, for example, can have sloppier medication administration because it's hectic," Kliger asserts, adding that through variation, the changes are readily shared and become a "library" that can be compared across hospital and unit settings.

It also is this customization that led to creative and often low-cost solutions. For example, one of the hospital's solutions, which later was picked up by many of the others, was the notion of a

Quality manager an important team member

The hospital quality manager should play an important role in the implementation of an Integrated Nurse Leadership Program (INLP), says **Julie Kliger**, MPA, BSN, RN, INLP creator and program director at the Center for the Health Professions, University of California, San Francisco; principal and founder of The Altos Group; and lead author of an article in the *Joint Commission Journal on Quality and Patient Safety* detailing the successful implementation on INLP in seven Bay Area hospitals that led to significant improvements in medication administration.**(See the article on pg. 16.)**

"For all these initiatives you need a central governing body that should be made up of your quality people, the pharmacy, nurses, and so forth, so you can oversee and guide the work being done at the unit level," Kliger explains. "This needs to be seen as a collective piece of work, to help units that are struggling, and to share the knowledge of those that are doing well. In particular, the quality people can run more data and talk with staff to convince them of the importance of the initiative."

The quality manager also can play a role in convincing the administration that QI initiatives such as these are worth undertaking. According to Kliger, it is an easy pitch.

"Fundamentally, when I go to speak to hospital executives about this model, it's all about improving outcomes," she says. "And the hospitals have to do this anyway — improve outcomes, reduce malpractice and risk — so it aligns with their mission and organizational goals."

The "pitch" is now strengthened by a business case analysis conducted following the San Francisco study. "We had a very positive ROI [return on investment]; even if you fold in the costs (of retaining her services) and releasing the staff to do medication administration, it will come in at over 150%; so it's not only the right thing to do but it saves more money than you would by doing nothing," says Kliger.

According to the Institute of Medicine, Kliger adds, the cost of each medication administration error averages out to $10,600. "When you have a baseline error rate of 20%, and decrease that by 88% like we did, you save a lot of money — not to mention [avoiding] possible litigation," she says. ■

communication tree. "One med/surg unit decided that too many nurses needed to communicate via e-mail, which was not very effective because not many people would actually read them," says Kliger.

If you picture a tree with branches, she continues, each member of the team had a name on a branch, and each leaf was the name of somebody they were responsible for calling. "Whenever there was a substantial change in policy, procedure, or you needed input from members of the team, 10 members reached out to 60-plus staff," says Kliger. "It was a more personal touch and made a big difference; somebody else downstream couldn't say they didn't know about the change. It also fostered buy-in."

Another solution addressed the problem of distractions and interruptions. "One of the units wanted to decrease interrupting phone calls during their protected hour of medication administration," Kliger explains. "They developed a process whereby the ward clerk identified who the caller was and read from a script telling how the nurses were involved in an important patient safety activity and couldn't be pulled out of it to talk."

The clerk then drew either a happy face or a frown face, indicating whether the customer was satisfied. "They amended the scripts over time and kept a log on whether there were more happy faces or frown faces," Kliger adds. "It did not cost any more money and directly determined if they were strategically communicating; people felt better about it. When someone absolutely had to be transferred, the charge nurse was brought up to speed on all the patients."

Ensuring compliance

The program also involved compliance tracking activities. For example, every month there were two small data measures of 10-measure sets. "Twice a month we would 'naively' observe 10 medication administrations," Kliger shares. "And every month we would have two data points — such as interruptions or labeling — and every month we'd see if the 'test of change' worked; that informed the next steps."

The goal, of course, is to keep the trend of errors on a downward slope. "We need to be at 90%-95%, so the goal is to strive that way," says Kliger. "When I visited with teams, they'd be reviewing how the data looked on each of the units. We developed an Excel-based electronic

dashboard, which included raw data, percentages, and graphs, so the frontline staff could look at their progress, and at the governance level they can see an organizational error rate."

The method is apparently working. "We now have 36 months of data on the pilot units; all seven hospitals are either maintaining or improving their rates," Kliger reports. "And during that time we were spreading the program to all units in the hospital, adding complexity, which is hard to do."

The teams meet regularly, and it's important for them to have data to look at in order to sustain improvement, Kliger continues. "Data are like the headlights on a car," she notes. "If things are not working, then you draw on leadership skills and how you present the data; that's how you get people coming on board."

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Reference

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First the RACs, now wait for what's coming next

Medicaid, commercial insurers starting their audits

By the end of the year, it's likely that every type of medical record in your hospital will be scrutinized by one auditor or another, predicts **Brian Flood**, managing director for KPMG LLP, the U.S. audit, tax, and advisory firm.

"It's a new world for health care. Medicaid is rolling out its Medicaid Integrity Contractor [MIC] program to audit Medicaid records, and commercial insurers are beginning to use the same model — and, in some cases, the same auditors — to review the records of their members," he adds.

The Pennsylvania Department of Public Welfare's Bureau of Program Integrity has been auditing fee-for-service Medicaid claims for the past three years, using one of the Centers for Medicare & Medicaid Services (CMS) contractors for the Recovery Audit Contractor (RAC) demonstration project, reports **Charleeda Redman**, RN, MSN, ACM, director of corporate case management for the University of Pittsburgh Medical Center, an integrated health system with 20 acute care hospitals.

Key Points

- Auditors could look at quality issues as part of the continuum of care, such as readmissions.
- Pilot program provides information about RACs but not much information about MICs, which could vary by state.
- Largest providers in largest population centers likely to be first MIC targets.

The contractor has been auditing records retrospectively and recovering payment if there was a coding error or the patient didn't meet medical necessity criteria, she adds.

CMS has contracted with a different auditor to handle its MIC audits in Pennsylvania, but it will use a similar process, Redman says.

"The MIC auditor will request charts and make determinations. We will appeal through the Department of Public Welfare," she says.

The auditors may have different targets based on the contracts or scope of work they have with the state Medicaid office, Redman adds.

"Some quality issues have been identified as potential risks. In addition, the auditors are looking at the continuum of care, such as cases that are readmitted within a certain time frame," she says.

In addition, a large commercial insurer has contracted with the same contractor used by the Department of Public Welfare to audit medical records in Pennsylvania with a focus on DRG validation. Another commercial health plan has a contract with another firm to review the records of its members for both medical necessity and coding, Redman says.

"The commercial insurers contract with vendors to audit specific areas where they have identified potential risk. So far, the contracts have varied from payer to payer," she adds.

Thanks to the three-year pilot program, there's a lot of information available on the RACs and what the auditors focused on during the pilot project, and hospitals can use that information to get ready for the permanent RACs.

In comparison, information on the MICs is not readily available, and hospitals can't base their expectations on the experiences of other hospitals because what the MICs are focusing on may vary from state to state.

The auditors hired by commercial insurers may focus on a totally different area, depending on the contract specifications from each insurer. This means that the commercial audits may vary from insurer to insurer and possibly from hospital to hospital, depending on the terms of the contract.

The MICs are selected by CMS but will interact with each individual state's integrity program. This means it's more than likely that MICs will operate somewhat differently in every state.

"The MICs will be consistent in how they perform the audits, but they may be looking at different issues. In the beginning, the MIC focus is likely to be very similar to the focus of the RACs, but they may get into the finer details in the coming years," Flood says.

The MICs are going to focus on issues that are continually problematic in Medicaid, Flood points out.

Likely MIC targets

Upcoding, lack of documentation to support the coding that was billed, unbundling, violation of time-base codes for outpatient therapy and inpatient therapy services, imaging services, durable medical equipment usage, and medical necessity issues are likely to be MIC targets, he says.

The MIC process is different from the RACs in several ways.

MICs must conform to state laws in terms of time for hospitals to respond to their requests for data; so the time providers will have to respond will differ from state to state. Generally, requirements are between 15 and 45 days.

The RACs are limited to requesting data that go back three years, but MICs base their length of time on regulations in the individual states or the allowed rules of evidence based on the continuing nature of the activity being reviewed, Flood says.

MICs have no limits on the number of records they can request, while RACs are limited to 200.

In Arkansas, the MICs have been reviewing 100% of the records from 100% of providers, Flood reports.

Unlike with the RACs, CMS will not reimburse providers for copying medical records requested by the MICs.

MICs are not paid by contingency fees but on a contracted basis, plus an award for performance during the contract year, which gives them an incentive to dig deep and identify as many improper payments as possible, Flood adds.

The MIC process was expected to be rolled out nationwide in January, when the last task orders were to be assigned and the auditors are able to get staff on board. The MICs will audit the medical records of Medicaid managed care patients as well as fee-for-service patients. The process is expanding beyond inpatient services and will include outpatient treatment as well.

"Since many states have gone to a capitated rate and 60% of Medicaid patients are in managed care, if the MICs audit only fee-for-service beneficiaries, they'll miss an entire population," Flood says.

In addition to auditing hospitals, MICs will audit long-term care facilities, pharmacies, physician practices, labs, transportation providers, and other types of providers.

Largest hospitals probably first

When the MICs begin their audits of hospitals, the first targets likely are to be large hospitals or health systems in large population centers, Flood says.

"The MICs are picking organizations to audit based on population and growth. The largest providers in the largest population centers are likely to be first, but they eventually will get around to every facility in the state," Flood says.

Most of the MIC audits are likely to be "desk audits" — in which the auditors request records and audit them off site. However, the MIC auditors also may come in person to the hospital to review records and interview providers and their office staff.

In addition to auditing providers for coding and medical necessity issues, the MIC protocols require the auditors to review organizations for their handing of billing and costs and to begin measuring for governance of risk, Flood says.

"The MICs will be going beyond case management to determine how the hospitals are running the operations side of the medical encounters and how it impacts the financial side," he says.

For instance, if an auditor asks for certain files, the hospital has to be able to find them and deliver them on time.

The auditors also can ask to see organizational charts, such as a chart showing how the organization deals with overseeing risks and how internal

audits are conducted.

They may look at the organization's compliance efforts, how many staff are responsible for compliance, what the budget is, how many audits are conducted each year, and what the results have been, Flood adds.

MICs get to heart of operations

"The MIC auditors are looking for a lot of different issues that the RACs did not focus on. Their scrutiny goes straight to the heart of the operations at the institution," he says.

For instance, if a hospital's compliance department has 25 full-time staff, extensive policies and procedures, regularly scheduled audits, and a database of audit results, the MIC auditor is likely to conclude that the organization has a good governance structure, he adds.

On the other hand, if the hospital has a part-time compliance office with no staff, and no clear description of what he or she does, the facility is likely to receive a lot of scrutiny from the auditors, Flood adds.

"When the auditors write their reports, they will note standard issues, including documentation and proper billing. The governance report will go to the state Medicaid integrity director, which will get the hospital on the radar of the state program immediately," he says.

As part of the Deficit Reduction Act of 2005, Congress required CMS to establish the Medicaid Integrity Program and hire contractors to review provider activities to determine if fraud, waste, or abuse has occurred; audit provider claims; identify overpayments; and conduct provider education.

There are three types of MICs: Review MICs, Audit MICS, and Education MICs. Review MICs analyze electronic Medicaid claims data and identify issues for the Audit MICs to pursue. Education MICs are charged with educating providers, state Medicaid officials, and others on Medicaid payment integrity, quality of care, and other issues.

When the MIC process begins, the institutions will receive a nine-page questionnaire and have 15 days to answer it before an entrance conference with the MIC auditor, Flood says.

An example of a question on the questionnaire is "Please tell us all the instances you had to pay back state and federal funds, the reasons, and the amounts," he says.

The entrance conference may be on site or on the telephone and will include a document request and a time frame, typically 30 to 45 days, in which the hospital must respond.

After the audit is completed, the MIC will prepare a report that will be shared with the state and the provider. The state and the provider will be able to review and comment on the draft report.

CMS will use the information from the reviews to prepare a revised draft report and send it to the state for review and additional comments. Then CMS will identify any overpayments and send the report to the state to collect. Once the final report is issued, the appeals will be handled through the state appeals process.

"There is no appeal for providers at the federal level, even though these are federal contractors doing the work," Flood says.

*(For more information, contact: **Brian Flood**, managing director, KPMG LLP, e-mail: bgflood@kpmg.com; **Charleeda Redman**, RN, MSN, ACM, director of corporate case management, University of Pittsburgh Medical Center, e-mail: redmanca@upmc.edu.)* ■

Hospital reimbursement from all payers is at risk

Take proactive approach to responding to auditors

If your hospital has been focusing solely on improving Medicare records in preparation for the permanent Recovery Audit Contractor (RAC) program, you may find yourself in a bind as other payers roll out their own audit programs.

"There has been a lot of emphasis on the RACs, but in Pennsylvania, we've experienced other audits, and it's just a matter of time before other state Medicaid organizations and other commercial insurers are going to roll out their audit programs. It's no longer just Medicare reimbursement that's at risk; it is truly an organizational risk across all payers," says **Charleeda Redman**, RN, MSN, ACM, director of corporate case management for the University of Pittsburgh Medical Center (UPMC).

Hospitals should prepare for the MICs and the commercial auditors in much the same way as they have been preparing for the RACs, and develop an organized group, similar to the RAC committee, with well-defined roles with each discipline, says **Brian Flood,** CHC, CIG, Esq., managing director for KPMG LLC.

The committee should start immediately to

Key Points

- Develop a committee to deal with MICs and commercial insurance auditors.
- Define the record request by type and track deadlines, which may vary.
- Make sure letters from auditors are looked at directly by the appropriate area.

get a coordinated plan in place to respond to the MICs and other auditors before they start getting requests for information because the response time is likely to be very short, he adds.

Develop a committee

To prepare for the audits, UPMC developed a steering committee made up of representatives of key departments including health information management, coding, care management, finance, compliance, and risk, Redman says.

The committee diagrammed the document flow for all audits, including the agencies involved. The group developed an internal process that includes tasks, tools, and turnaround time for all appeals.

UPMC has a dedicated staff for the appeals process specific to the external audits. The current scope of work is handled by a 0.5 FTE RN and a 30-hour-a-month physician who handles medical necessity appeals. The audit work is only a portion of the work done by those individuals, Redman says.

Facilities that focus on responding to just one type of audit are not going to be successful in the end, because the various auditors may use different criteria, Redman points out.

"The time frames are different. The roles are different, and the addresses where you send your responses are different. If you can't automate your response system, it will be difficult to manage," she says.

It is essential for hospitals to develop a comprehensive electronic system that can define the record request by type and track the deadlines and responses, Redman suggests.

"So many software vendors are focusing on RACs and Medicare, and they don't offer the ability to track three different audit types. That is going to be essential as the MIC audits and those by commercial insurance are rolled out," she says.

Hospitals that are part of a health care system should develop a process to oversee the responses to make sure they are covered systematically, rather than by each individual hospital, Flood suggests.

The team at UPMC has created a central department to handle all record requests and appeals from each facility.

"We're working to change the initial requests for documents so they come to a central area. Once we get a letter, we enter who the auditor is and what the request is. This method will give us the ability to drive the work flow to the area that can respond and track where the charts need to be sent and the time frame," she says.

For instance, if an audit determines that a payment was improper, the letter is forwarded to health information management to review and respond if it's a coding issue. If it's a care management issue, it's sent to care management.

Redman's department handles any issue related to medical necessity, quality, and continuity of care.

Make sure that any letters that come into the system are immediately sent to the area that is responsible for responding, Redman says.

"The clock starts ticking from the day the letter is sent out. If you don't manage the process, you can't meet the deadlines and have no ability to appeal," she says. ■

Follow-up calls help avoid readmissions

CMs identify problems and work to solve them

In an effort to improve transitions of care, the nurse care coordinators at Brigham and Women's Hospital in Boston make follow-up calls to patients who have been discharged, identify problems and solve them, and answer questions the patients may have about medication, symptoms, or their discharge plan.

"One of the biggest benefits of the follow-up monitoring program is preventing hospital readmissions and visits to the emergency room. By calling the patients shortly after they are discharged from the hospital, we can discover any potential complications and proactively address them. While we don't have statistical data, we do have a lot of anecdotal information that demonstrates we have been able to intervene and solve problems for the patients," says **Christine Dutkiewicz**, RN, MSN, CCM, care coordination nurse manager at the 777-bed hospital.

The hospital has an average of 53,693 discharges and 59,323 emergency department visits each year and had a 30-day readmission rate of 8.79% for medical-surgical patients in 2009.

The Massachusetts Department of Public Health requires hospitals to follow up on patients who are discharged with multiple services or otherwise complex post-hospital needs or lack an informal personal support system.

At Brigham and Women's, nurse care coordinators are assigned by service line and follow the patient throughout the hospital stay. The same care coordinator who made the discharge plan makes the follow-up calls within a day or two after the patient is discharged, Dutkiewicz says.

The nurse care coordinators call any patient who is discharged home with post-acute services, patients who will be home alone after a hospital discharge, first-time mothers discharged to home with their babies, families of babies who are discharged from the neonatal intensive care unit, and any patient the care coordinator is concerned about after discharge.

The nurse care coordinators use their clinical judgment in determining the timing of the call based on past service utilization, access to care, and medical and social complexities.

They also call patients who are discharged from medical oncology and bone marrow transplant and patients who are discharged from thoracic services. The cardiac surgery service handles its own follow-up calls using its own distinct database.

The nurse care coordinators access clinical and demographic information about patients through an ambulatory electronic record. Using a standard template, they ask a series of questions about the discharge process, the adequacy of home care services, family support, pain management, medication, activity restrictions, and follow-up appointments.

They enter the information from the call into a longitudinal database that is accessible by other providers in the Partners Health Care System, which includes Massachusetts General Hospital, Brigham and Women's Hospital, three community hospitals, two long-term acute care hospitals, two rehabilitation hospitals, four skilled nursing facilities, a home care agency, a hospice, and more than 1,000 primary care physicians who practice throughout the state.

The nurse care coordinators use a follow-up monitoring template that includes the reason for admission, information about how the patient is feeling, pain management, medications, wound/incisions, activities, home care visits, follow-up care, nurse care coordinator follow-up and referrals, and questions or concerns.

Each section has a drop-down menu that includes a series of questions in which the nurse care coordinators enter details about each patient response.

For instance, within the pain management section, the questions include: Is the patient feeling any pain or discomfort? How is the pain on a scale of 1 to 5? Does the pain medication help? Is the level of pain acceptable to the patient?

There is a list of types of medication (antibiotics, steroids, diuretics, etc.) and a list of types of questions (dose, frequency, side effects, duration, etc.) that the nurse care coordinators can record electronically using a check-off or point-and-click method.

Key Points

- Nurse care coordinators, who follow up with patients after discharge, are assigned by service line and follow the patient throughout the hospital stay.
- Patients who are discharged home with post-acute services, those who will be home alone after a hospital discharge, first-time mothers discharged to home with their babies, families of babies who are discharged from the NICU, and any patient the care coordinator is concerned about after discharge are called.
- Coordinators use a template to gather specified info from discharge patients.

Automated e-mails

The system automatically formats an e-mail that the nurse care coordinator can send to the primary care physician, home health nurse, or other providers if they have concerns about the patient. The e-mail includes the reason the care coordinator is asking for the follow-up and all the information gathered during the call.

When the nurse care coordinators uncover problems that might have occurred during the hospital stay, they send a report to the appropriate department leaders of individuals within the hospital, Dutkiewicz says.

"This is important information to share within the hospital to drive improvement activities," she adds.

Originally, the care coordinators documented their follow-up calls using a database that was accessible only to the care coordination department employees. The department has moved to

an integrated system to enhance patient transitions, quality, and access, Dutkiewicz says.

The nurse care coordinators print a daily report of patients who were discharged the day before and use that to set up their call schedule. They start calling in the morning, make two attempts to reach the patient, and leave a message asking the patient to call back if the calls are unanswered.

The care coordinators always instruct the patient to call with any questions or concerns but it doesn't always happen, she says.

"Using this system, we take a proactive approach to identifying any questions and problems the patients are having and solving them before the patients are back in the hospital or the emergency room," Dutkiewicz says.

The majority of questions patients have concern medication or symptoms after surgery.

"Often, patients don't understand their discharge instructions. The entire episode of care, including discharge, may be overwhelming. Patients may not feel comfortable calling their doctor's office if they have questions or concerns. They wait for the symptoms to exacerbate before calling," Dutkiewicz adds.

The nurse care coordinators sometimes find that patients haven't filled their prescriptions due to costs or previously unknown preapproval requirements. Other times, the durable medical equipment hasn't arrived or the home health agency hasn't scheduled a visit.

"When we identify these problems, we work to solve them. We've even called 911 for patients when we were concerned about the acute nature of their reported symptoms," she says.

The care coordinators talk to the spouse or caregiver if the patient is unable to come to the telephone. If the patient is sent home with hospice care, they call hospice first, and then call the patient and family.

The follow-up calls help other providers in the Partners network coordinate care for the patients after they are discharged from the hospital, Dutkiewicz says.

For instance, if a patient comes into a community hospital's emergency department, staff can access the record and see the patient history and the care coordinator's report after the patient was discharged.

"Many changes need to happen in health care to improve patient outcomes. With public reporting of quality outcomes, payment, and health care reform, there is an additional incentive to conduct integrated follow-up monitoring of patients after they are discharged from the hospital," she adds.

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Studies show decrease in senior care continuity

End-of-life discussions should be reimbursed

If the discharge planning community's ideal is to begin the discharge process at the door, when patients are admitted to the hospital, then community provider input is necessary for a smooth care transition.

But care continuity has been low, and it's decreasing for older adults, recent studies show.[1,2]

A study that examined the proportion of patients who are seen by their primary care physician during their hospitalization found a significant decline in this continuity of care, says **Gulshan Sharma**, MD, MPH, an associate professor at the University of Texas Medical Branch in Galveston.

"The proportion declined from 50.5% to 44.3% between 1996 and 2006," Sharma says.[2]

The study showed an even greater decrease in continuity in cases where patients were admitted to the hospital on weekends and for those living in large metropolitan areas.[2]

The results were not too surprising, given the

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changes that have taken place in the delivery of health care over the past two decades, Sharma notes.

"To improve efficiency of care, you have primary care physicians managing patients in very busy practices, and it's hard for them to go see patients who are hospitalized," he explains. "So there's been a large growth in hospitalists' positions, and these are the people who provide care for patients when they're hospitalized."

The older model of having one physician follow patients through the trajectory of their illness and care no longer is followed.

"The health care system is getting more efficient, with physicians spending more time at their part of this system, but the price you pay is fragmented care," Sharma notes.

"There's a lot of disruption in care, and there's no major effort to have a physician make sure the transition is smooth in either direction," he says.

Similarly, there are no practice or economic incentives for hospitalists to follow up with patients once they've returned to the community, Sharma adds.

"That's where a major discussion is going on: How do you make this transition smooth?" Sharma says. "One way would be through an electronic health record."

Hospital systems and community providers who can connect electronically can provide follow-up care and a smoother transition through electronic communication, he says.

But research suggests that having a primary care provider attend a patient in the hospital can improve health care outcomes. In one study, investigators found that patients with terminal lung cancer who were visited by community physicians while in the hospital were less likely to spend time in the intensive care unit (ICU) before death.[1]

"So it might be good for discharge planners to have a primary care physician visit patients," Sharma notes, "and discharge planning should include communication with a patient's primary care physician, so they'll know what's going on."

One reason those primary care physician visits to hospitalized patients are decreasing is that there is no reimbursement for them, he says.

"Medicare won't reimburse for two physicians for the same specialty," he explains. "So, if you have an internal medicine doctor providing care and a primary care physician who also sees the patient, then whoever sends in the claim first gets paid."

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