HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

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To prevent readmissions, coordinate services post-discharge

Take proactive approach to what happens beyond hospital walls

The best way to prevent hospital readmissions is to make sure patients are better managed and receive the care they need after they leave the hospital, states **Donna Zazworsky**, RN, MS, CCM, FAAN, vice president of community health and continuum care for Carondelet Health Network in Tucson, AZ.

In addition to reducing the length of stay, the goal of a discharge plan should be to prevent readmissions by improving the coordination of services the patient receives after discharge and by bridging the gap between the hospital and the patient's post-acute destination, whether the patient is going home or to a facility at another level of care, she adds.

Hospitals traditionally have been reactive rather than proactive when it comes to readmissions, and that needs to change, Zazworsky says, particularly as the Centers for Medicare & Medicaid Services (CMS) moves toward denying payment for patients with some conditions who are readmitted within 30 days of discharge.

"What hospital case managers need to do is look at what measures they can put in place to prevent patients from coming back," she says.

To ensure a smooth transition to the next level of care, make sure that the next clinician who will see the patient has timely information about what happened in the hospital, suggests **Cory Sevin**, RN, MSN, NP, director of the Institute for Healthcare Improvement, a Cambridge, MA-based nonprofit organization with the mission of improving health care.

"When somebody goes home, the primary care physician should be alerted and should receive information on what happened in the hospital, what medications were prescribed, and whatever other information they need to have to act on behalf of a patient. If a patient is going to another level of care, that provider should also

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have timely and comprehensive information," she says.

Lack of medical supervision in the community is one of the biggest factors in hospital readmissions, says **Elaine Keane**, vice president for business development for Visiting Nurse Services of New York, a home care organization that collaborates with hospitals in the area on programs to reduce readmissions. (**For more information about follow-up care for patients, see related article on page 69.**)

With the advent of hospitalist programs in many hospitals, a patient's hospital episode is separate from what has happened with the patient in the community, Keane points out.

"For patients to have a successful stay in the hospital and transition to the community, providers need to share information across the continuum of care," Keane says.

A cross-continuum team that works together to improve transitions of care is a key component of the Institute for Healthcare Improvement's hospital collaborative, which bring teams from 30 to 60 hospitals and other organizations together over a 12-month period on process improvement projects to improve care, Sevin says.

Working with a cross-continuum team was a big factor in helping St. Luke's Hospital in Cedar Rapids, IA, reduce readmissions, adds **Peg Bradke**, RN, MA, the hospital's heart care services director. (**For details on St. Luke's initiative to reduce readmissions, see related article on page 70.**)

"It's nice to have a comprehensive team. If you are just working within the hospital, you are missing the bigger picture. The representatives from the clinic, home health, and the post-acute facilities look at things from a different point of view from the hospital staff. Getting the patient's perspective is also a very important component of our program," she says.

Along those same lines, Zazworsky recommends working with community providers to develop memoranda of understanding with details on what information the hospital will provide and how the patients will get follow-up after discharge.

"Many patients are readmitted to the hospital because they don't have what they need to stay stable once they are discharged back into the community. If patients don't have the basic things they need to take care of themselves, it can derail a discharge," Sevin says.

For instance, patients need to understand their treatment plan and their medications, transportation to the pharmacy so they can get their medications right away, a follow-up visit with a physician within a week after discharge and a way to get there, and food that will be good for them, she says. (**For more information on patient education, see related article on page 68.**)

Look for barriers, such as cost and lack of transportation, that could prevent patients from receiving post-acute treatment and problem-solve

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before the patient leaves the hospital, Zazworsky suggests.

"There's a lot that hospitals need to take care of when they're getting ready to discharge someone. Ideally, the case managers should start on admission to understand the needs that the patients will have when they go home," Sevin says.

Make sure that you identify the family caregivers and whoever else needs to know what kind of care the patient will need after discharge, she says.

"It's really important for the case managers to fully understand the complex needs of their patients. They need to take a lot of care with the assessment process and not just interview the patient and check off the boxes," Sevin says.

Work with patients to make sure that they can pay for any outpatient services or medications that are not covered by insurance, and help them get assistance if they can't pay, Zazworsky says.

"It's important for case managers to understand their patients' health plans and, if something isn't covered, go back to the doctor and see if the treatment plan can be changed," she says.

To ensure a successful discharge, case managers should educate patients about their disease process and what can affect their recovery and make sure they have the resources to manage their disease.

They should coordinate all the multiple aspects of care the patient will need after discharge and make sure they are in place, Zazworsky says.

For instance, if patients have heart failure, give them a scale, and have them demonstrate how to weigh themselves and record it.

"If patients have trouble seeing the number on the scale, it doesn't do much good to ask them to weigh themselves," she adds.

Make sure patients with diabetes get a glucometer that is covered by their health plan before they leave the hospital.

"Have the glucometers available for them, because nine times out of 10 if they leave the hospital without a glucometer and are newly diagnosed, they won't get it for a few days. When they're in the hospital is an opportune time to make sure they know how to use the glucometer," she adds.

Help patients with a chronic disease such as diabetes enroll in a self-management program, she adds.

Create a tool box for your unit or the case management department as a whole that includes information on internal and external resources, community programs, and health centers, support groups, and resource booklets, she says.

When patients are frequently readmitted, drill down to determine why, Zazworsky suggests. For instance, if a patient with diabetes keeps coming back with sepsis or pneumonia, it may be because the diabetes isn't under control, she points out.

"Always look for ways to improve the system. Determine where pieces are falling through the cracks as patients transition and develop strategies to bridge the gap," she says.

Develop guidelines for patients at risk for rehospitalization, Zazworsky suggests.

For instance, her health system has created an action plan for hospitalized patients with diabetes that tells them exactly what to expect when they are in the hospital.

The patients also receive a card that outlines recommended tests and procedures and the optimal results. For instance, the card shows how often patients should have a hemoglobin A1c test and what the results should be.

Make sure that patients are prescribed appropriate therapies, such as beta blockers, statins, and insulin therapy at discharge, and that they understand how and when to take them.

Hospital case managers should give patients clear, concise, and comprehensive written information on how to take their medications, Zazworksy says.

She says one patient was supposed to take one medication three times a day and another five times a day but took them all before noon so he'd be sure to remember.

"As nurses in the hospital know, patients tend to refer to their medication as 'pink pills' and 'green pills' rather than being familiar with the medication name and what it's for. As community case managers, we see many patients who are not taking their medication properly," she points out.

Make sure the patients, family members, and caregivers understand what the medications are, when to take them, and make sure that they get their medications right after they are hospitalized, Sevin says. Make sure that they can pay for their medications, and if they can't help them connect with organizations that can help with the cost.

Develop a mechanism to identify high-risk patients who need help transitioning to the community, Zazworsky says.

Arrange for at least one home health visit for patients who are at risk for readmission, she adds.

Visiting Nurse Services of New York's program to reduce readmissions for heart failure program has resulted in a decrease in hospitalizations and emergency department visits for patients, Keane

reports.

At one hospital, analysis of patient data before and after the program started showed that emergency department visits for heart failure patients in the program decreased by 40%, readmissions decreased by 41%, and readmission days dropped by 36%. At another hospital, data for about 300 patients are still being analyzed, but results show that rehospitalizations have been reduced, Keane adds.

The heart failure readmission programs are a collaborative effort between the Visiting Nurses Association and hospitals and is tailored to meet each hospital's specific needs, but all have similar components.

All heart failure patients who are admitted to the hospital are referred to the program. A nurse from VNS does a risk screening when the patient is in the hospital, starts the educational process, and offers the patient the opportunity to participate.

"The intake role has transitional care nursing embedded into it. When we work with patients in our heart failure readmission program, the intake nurse plays a broader role in terms of getting the care started and engaging patients in health education before they go home," Keane says.

Home care nurses visit the patients after discharge and conduct a comprehensive educational program over the course of several visits, as well as making sure the patients understand their medication regimen and have a follow-up visit with a physician.

"We work with the patients and their caregivers to develop treatment goals and a plan for what the patients should do if the symptoms present," Keane says.

(Editor's note: Donna Zazworsky's web conference CD "The Case Manager's Role in Transitioning to the Community" is available at http://www.ahcmediainteractive.com/.)

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Make sure patients understand disease

Tailor patient education

When **Donna Zazworsky**, RN, MS, CCM, FAAN, vice president of community health and continuum care for Carondelet Health Network in Tucson, AZ, ran a community case management program for high-risk congestive heart failure patients, she was surprised to discover that many of the patients did not understand their diagnosis or their discharge instructions.

"About 50% of patients don't understand what to do after discharge. When the discharge instructions are complicated and the person is ill and frail, it's even harder to make sure they understand," adds **Cory Sevin**, RN, MSN, NP, director of the Institute for Healthcare Improvement.

Before they leave the hospital, patients need to know what is wrong with them and what the condition will mean to their long-term health, such as how it will affect their ability to function, if it will increase susceptibility to other health problems, and factors that will decrease the possibility of a recurrence, Zazworsky says.

Make sure that patients understand where they are going after they leave the hospital, know what to expect, and know that they have access to follow-up care, Zazworsky recommends.

Case managers should educate patients on what they need to do when they get home, including any dietary restrictions, fluid intake, exercise restrictions, appointments for tests and other follow-up visits, and return to work, she adds.

In addition to ensuring that patients have a follow-up visit with a physician, make sure they understand that if they feel worse or begin to have symptoms, they should call their physician's office immediately and not wait until their appointment, Zazworsky adds.

"Patients often leave the hospital, and they don't know who to call, when to call, or how quickly to call if they have problems. They should have written information on who to call after discharge if they have questions or concerns," she says.

Make sure that the information and materials you give patients fits with their cultural backgrounds and that they understand it fully,

Zazworsky says.

"As case managers and discharge planners, we need to be aware of how we address the questions that need to be answered for the patient before discharge," Zazworsky says.

Health care professionals need to communicate with patients in ways that they can understand so they can use the information, she adds.

Don't overwhelm patients with a lot of information. Instead, focus on the key things they need to know, and make sure the information is clear and concise and that they understand it, Sevin says.

This includes medication instructions, what symptoms mean they should call their physician, and who they should call.

Be specific around each patient's clinical condition, she says.

Use the teach-back method to make sure patients understand.

"Nurses are taught to educate by telling people things. This isn't very useful. If they ask the patient to repeat what they have been told, it can close the loop," she says.

Make sure the messages are consistent throughout the continuum of care.

"To be more effective, the home health nurse should be providing the same information as the nurse on the hospital unit. Patient and family members should be hearing the same message and not being confused by multiple ways of teaching," Sevin says.

"Many times, case managers make the assumption that patients who are educated understand everything you are saying, but that's not always the case," Zazworsky says.

For instance, if you tell a patient they can eat something in moderation, find out what moderation means to the patient.

No matter how good your discharge education is, it won't be effective if patients can't understand it, Zazworsky points out.

"When patients first come into the hospital, case managers should determine if they can read, understand, and act on the health education they are going to provide," she adds.

She suggests using the rapid assessment of adult literacy in medicine tool, part of the Case Management Adherence Guidelines developed by the Case Management Society of America, to determine if patients will be able to understand their discharge instructions of if they will need extra help.

The tool asks patients to pronounce a list of words. If it takes the patient more than five seconds to say the word or if it's mispronounced, it is incorrect.

Here are the elements of the tool:

- fat;
- flu;
- pill;
- allergic;
- jaundice;
- anemia;
- fatigue;
- directed;
- colitis;
- constipation;
- osteoporosis.

Fat, flu and pill are not scored.

"A patient who scores six or less is at risk for poor health literacy. This means that you have to spend more time explaining specifically what you mean when you give discharge instructions and should make sure that they understand," she says. ■

Follow-up visits critical to prevent readmissions

Work with physician offices

Patients are at highest risk for readmissions during the first week after discharge, **Donna Zazworsky**, RN, MS, CCM, FAAN, points out.

That's why it's critical to make sure that patients have a follow-up visit with a primary care physician or a specialist within a week of being discharged from the hospital, adds Zazworsky, vice president of community health and continuum for Carondelet Health Network in Tucson, AZ.

"Case managers can do a wonderful job of educating patients, but if they don't get that follow-up visit, they are likely to have problems after discharge that could result in a rehospitalization or emergency room visit. The linkage to the community beyond the hospital walls is critical," she says.

Make sure patients have a follow-up visit before they leave the hospital and work with the patient and family to make sure they have transportation to get to the appointment, she adds.

Work with the clinics or physician offices in your area so they will give a discharged patient a priority office visit, rather than putting appoint-

ments off for several weeks, she says.

Identify the physician organizations that provide primary care for the majority of patients you discharge and invite their practice managers to the hospital for a meeting.

Keep in mind that physician office schedulers go by protocols when it comes to scheduling visits, but the practice managers can get your patients in for a visit if it's necessary, she says.

Zazworsky attends the monthly meetings of the practice management organization and works to make sure there are transitions in place.

"Case managers need personal contacts to make sure that patients get what they need after they leave the hospital," she says.

Patients who receive care from medical residents at the hospital clinics where there is a tremendous turnover and they don't see the same physician each time and those who have numerous doctors involved in their care are more likely to be readmitted, reports **Elaine Keane**, vice president for business development for Visiting Nurse Services of New York, a home care organization that collaborates with hospitals in the area on programs to reduce readmissions.

Hospital case managers can make sure that patients have a medical home and that their primary care physician and any specialists all have information on what happens during the hospital stay, she suggests.

Make sure the physician office understands that the patient needs to get in within three to five days of discharge.

The patient-centered medical home concept is gaining ground in many communities, Zazworsky points out. A major component of the model is care coordination for patients in the primary care setting, she adds.

Hospital case managers should find out which practices in their area are adopting the patient-centered medical home model and connect with the case managers in those practices to facilitate care for patients after discharge, she adds. ■

Team targets readmission for heart failure patients

Program reduces rate to just 17%

After St. Luke's Hospital in Cedar Rapids, IA, launched a cross-continuum heart failure program, the rate of readmissions for heart failure patients dropped from nearly 30% to just 17%.

The program includes development of consistent educational materials used across the continuum of care, timely physician visits for follow-up care, and a home health visit within two days of discharge from the hospital for every patient with heart failure.

The hospital developed a heart failure team in 2001 to look at ways to reduce readmissions, but outcomes really improved when the hospital participated in the Institute for Healthcare Improvement's series on the Ideal Transition to Home, reports **Peg Bradke**, RN, MA, St. Luke's heart care services director.

"We learned that the heart failure team we were working with was just a hospital team and we weren't looking beyond the hospital walls at the big picture," Bradke says.

The original team included Bradke, representatives from social work, the cardiac step-down unit, the emergency department, the medical unit, and care coordination.

After the kick-off meeting with the Institute for Healthcare Improvement, the hospital representatives expanded the existing heart failure team to include clinicians and family members who provide care for patients after discharge. Among the additional team members are the director of nursing from a long-term care facility, representatives from home health agencies, a nurse from a physician practice specializing in cardiology, and the daughter of a patient who was a Stage 4 heart failure patient.

"Before we expanded the team, we had been rationalizing that the majority of our readmissions were Stage 4 heart failure and we couldn't impact that. By working with the cross-continuum team, we determined that there were things we could do to help the high-risk patients avoid readmissions," Bradke says.

One of the keys to the success of the initiative is arranging a home health visit for every patient who is discharged with a diagnosis of heart failure. All patients with a primary diagnosis of heart failure are enrolled in the program and receive a follow-up home visit, if they agree. Then, the heart failure nurse calls all patients seven days after discharge to find out how they are doing and to answer any questions or concerns.

The team looked at how many patients did not qualify for home care services but could benefit from a home care visit and found that many patients covered by Medicare did not qualify

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CRITICAL PATH NETWORK™

Transition reduced readmission rate for COPD patients

Program includes case management in the home

By developing and following a comprehensive plan to improve care and transition to the community for patients with chronic obstructive pulmonary disease (COPD), UPMC St. Margaret Hospital has reduced the readmission rate by 16% for patients with a primary diagnosis of COPD and by 27% for patients with pneumonia and a secondary diagnosis of COPD.

The program includes a comprehensive educational component that is used by all disciplines who work with patients with COPD, a redesign of the respiratory therapist work process, a shifting of some responsibilities from nursing to respiratory therapy to improve consistency, and creating the position of community case manager — someone responsible for meeting patients when they are in the hospital, visiting them at home, and educating them on their chronic lung disease and self-management techniques.

Representatives from the hospital worked with the Pittsburgh Regional Healthcare Initiative, a nonprofit agency dedicated to improving safety and quality in health care to identify areas where the hospital could improve outcomes and reduce readmission rates.

"Those meetings determined that COPD is an area where we could improve patient outcomes. The disease is the fourth-leading cause of hospital readmissions in Western Pennsylvania, and our hospital had one of the highest readmission rates at slightly over 25%," says **Isabel MacKinney-Smith**, BSN, RN, CCM, COPD community case manager.

The hospital created a multidisciplinary team that included primary care physicians; pulmonologists, who were the physician champions; nursing; respiratory therapy; physical therapy; occupational therapy; nutrition; home care; and representatives from the emergency department, electronic health records, and care management and quality departments.

The team examined the processes of care from the time patients with COPD arrived at the door, either through the emergency department or through direct admissions, and throughout the entire hospital stay until discharge.

The team found that a number of patients who were readmitted had underlying pneumonia with a secondary diagnosis of COPD.

"We included both patient populations — those with a primary diagnosis of pneumonia and a secondary diagnosis of COPD and those whose primary diagnosis was an exacerbation of COPD," she says.

The team also developed evidence-based physician order sets so that when patients with COPD presented in the emergency department or as a direct admission, the admitting physician could pull up the order set and order evidence-based care from the outset of that patient's admission.

During a two-day process improvement session, the team looked at the respiratory therapy work flow process for ways to improve it and reduce waste.

Team members shadowed the clinicians who provide care for COPD patients and determined that not all clinical disciplines were providing consistent education on breathing techniques and energy conservation and that not all patients were receiving consistent instructions on how to use inhalers.

The team members who monitored the respi-

ratory therapists noted there was a significant amount of waste in the therapists' work process. They observed that the therapists spent a lot of time walking back and forth between patient rooms and that they were writing their documentation on cards and then entering it into the electronic medical record at the end of the shift.

The team redesigned the respiratory therapy work carts to make room for a portable computer the therapists could use for real-time documentation.

Respiratory therapy took responsibility for the administration of the inhalers, previously handled by the nursing staff, so there would be more consistency on the teaching the patients receive on how to use them. Respiratory therapists also took responsibility for enhanced teaching on smoking cessation.

At the same time, the hospital added another full-time equivalent therapist to the department to accommodate the extra work load.

The team decided that all the disciplines who would be caring for the patients with COPD patients should use consistent educational materials. They researched what was available and identified a booklet that has comprehensive information about living with COPD.

"We wanted a consistent approach across all the disciplines. Now each discipline uses the booklet 'Living Well with COPD' as a basis for their teaching," MacKinney-Smith says.

The hospital created a new position, COPD community care managers, to assist patients with the transition from the hospital to home.

"We realized we had to incorporate care for these patients after they left the hospital in order to reduce readmission rates," MacKinney-Smith says.

While the patients with COPD are in the hospital, the entire clinical team educates them on why their physician has ordered each medication, how to take or use it, what to do in case of a flare-up, and how to keep their COPD under control rather than having it control their lives.

During the hospital stay, MacKinney-Smith visits patients and their family members in the room, explains the COPD home visit program, and offers them the opportunity to participate. The home visit program is strictly voluntary.

"We offer it to every COPD patient who will be discharged to home and are working to expand to assisted living and skilled nursing facilities in our area. The home program is voluntary and we give them the option of refusing it," she says.

The home visits generally last about an hour and a half and are tailored to meet the educational needs of the patients and their families.

During the visit, MacKinney-Smith completes a three-page home assessment to find out how much patients understand about their disease and their treatment plan and documents the teaching she does as well as the patients' areas of concerns. She then electronically transmits the document to the patient's primary care physician within 24 hours of the home visit.

"A lot of the information that I gather is helpful for the primary care physician. I include any issues and problems the patient is experiencing to make sure the physician is aware of it," she says.

When she visits the patients' homes, MacKinney-Smith looks for factors that could exacerbate the individual patient's condition.

"Home visits are very helpful in determining the patients' needs because when I see patients on their own turf, I can pick up on problems that wouldn't be apparent to the staff who see them in the hospital or the physician's office. Sometimes little changes can make a significant improvement in a patient's health," she says.

For instance, MacKinney-Smith always checks the patients' equipment to determine if they are cleaning and storing it properly.

"In addition to inhalers, many patients are using oxygen nebulizers or CPAP or BiPAP sleep equipment. When the equipment is first issued, the patients receive instruction on proper cleaning and maintenance, but sometimes their attention to detail falls by the way side over the years," she says.

She teaches the patients the physiology of COPD, how to avoid triggers to exacerbation, the importance of smoking cessation, and educates them about their medication.

"I tailor the teaching to each patient's particular inhaler and make sure they understand how to use them properly and when to use them," she says.

She shows patients breathing techniques that will help reduce shortness of breath, coughing techniques, energy conservation techniques, beneficial exercises and works with the patients to develop an action plan for managing their COPD.

"I help them identify how they feel when they are at baseline and what activities they can participate in when they feel well," MacKinney-Smith says.

She goes over the typical symptoms of a COPD

exacerbation and teaches patients what to do when they experience each of the symptoms. After the initial home visit, she follows up by telephone weekly for at least a month.

Most of the patients already have primary care physicians. If not, MacKinney-Smith helps them find a physician to see in the clinic for follow up.

She works with all patients to make sure that they see their primary care physician within seven days of discharge.

"We're continuing to work on the best way to get these appointments set up. The goal is to try to set up the appointment before the patient leaves the hospital. Sometimes it's not possible because the appointment has to be at a time that doesn't conflict with their caregivers' work schedule. If the patients don't have an appointment by the time I visit them at home, I try to expedite the process and get them in to see their doctor as soon as possible," she says.

With the price of medications soaring, affordability of medications has become a huge issue for COPD patients, MacKinney-Smith points out.

"The maintenance medications for COPD are among the most expensive on the market. Many of these patients are elderly and have Medicare Part D benefits but are entering the donut hole early in the year and having a problem affording their medicines," she says.

If patients are having trouble paying for their medications, MacKinney-Smith helps them access patient assistance programs and works with their primary care physician to help them get the medication free or at a reduced cost.

She encourages the patients to participate in the hospital's community education classes on COPD to enhance the teaching that's done in the hospital and the home. The classes include information on exercise and energy conservation, nutrition, medication adherence, the COPD action plan, and smoking cessation. They are free and open to patients and family members as well as members of the community and serve as a support group for people with COPD.

"The program has been very well received by patients and their families. They are happy to have the tools that help them know what to do to manage their chronic lung condition," she says.

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Be careful in discharging patients on Friday

They're more likely to be rehospitalized

Patients who are discharged to the hospital with home care on Fridays are more likely to be readmitted to the hospital within a week than patients discharged on other days of the week,[1] according to **Elizabeth E. Hogue**, Esq., a Washington DC-based attorney specializing in health care issues.

"The reasons for this disparity remain unclear, but one possible explanation could be that hospital discharge planners or case managers are anxious to discharge as many patients as possible before the weekend," she says.

If patients are sent home on Fridays when they really do not belong at home, they are more likely to experience deterioration in their conditions, which can put them back in the hospital, she adds.

Hogue recommends that case managers and discharge planners be especially careful when they discharge patients on Fridays with a referral for home health services.

If the patient is readmitted for the same condition, it may impact the hospital's bottom line and could put the person who created the discharge plan at risk for a lawsuit charging negligence, she adds.

"According to national standards of care in Medicare Conditions of Participation, discharge planners and case managers have a duty to develop and implement appropriate discharge plans. They may be liable if they breach this duty and cause injury or damage to patients," Hogue says.

Patients who are appropriate for post-acute services in the home must be able to either care for themselves or they must have a paid or voluntary caregiver available to meet their needs in between visits from the professional staff, Hogue says

In addition, case managers should be certain that their patients' clinical needs can be met at home and that their home environments can support home health services, she says.

"When one or more of these criteria are not met, discharge planners are putting themselves at risk for legal liability," she says.

In addition, discharge planners and case managers should make sure that all post-acute providers receive all of the information they need to effi-

ciently and effectively provide the care the patients need after discharge.

"Discharge planners and case managers must be sure to communicate complete and accurate information to post-acute providers. The tendency on Fridays may be rushing to get as many patients discharged as possible to the detriment of the planning process," Hogue says.

The Centers for Medicare & Medicaid Services (CMS) already is using the rates of rehospitalization as one of the quality indicators it uses to evaluate home health agencies, Hogue points out.

"This quality indicator will become more crucial when pay-for-performance is implemented because home health agencies' reimbursement will depend on low rates of rehospitalization," she says.

The response by home health agencies may be to decline to accept patients on Fridays in order to lower rates of rehospitalization, Hogue points out.

"It is clearly in the best interest of both discharge planners and post acute provider to further consider the disparity in rehospitalization rates and to work together to reduce it in order to manage risk and maintain reimbursement rates that support financial viability," Hogue says.

REFERENCE

1. Rowan, T. (October 26, 2006). Data analysis exercise: Beware of "Friday's child." *Home Care Automation Report*.

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CPT changes a start, but more could be done

The Current Procedural Terminology (CPT) code changes in place in the 2008 Physician Fee Schedule improve the ability of physicians and other providers to document their telephone evaluations and management services, but they don't go far enough, according to the Case Management Society of America (CMSA).

The current schedule includes codes related to the delivery of case management services, but these have been given a Status N, which means they are not payable by Medicare.

So CMSA is working with the Centers for Medicare & Medicaid Services (CMS) in support of providing Medicare reimbursement for these codes.

Case managers work directly with patients in support of medical management and health care coordination, including providing health adherence assessment, education, and adherence monitoring during the discharge process.

A number of health care organizations have established or piloted programs in which discharge planners or case managers have called patients at home some days or weeks post-discharge to assess their health and continued treatment adherence. The CMS codes acknowledge the importance of such telephone services.

The three non-physician codes, issued for telephone services, include these:

- **98966**

Telephone assessment and management services provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days or leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion.

- **98967**

11-20 minutes of medical discussion during telephone assessment and management services.

- **98968**

21-30 minutes of medical discussion during telephone assessment and management services.

There are three similar codes established for telephone evaluation and management services provided by a physician.

All six of these codes are Status N, but they have Relative Value Units associated with them, meaning that private payers may cover them.

CMSA says the solution is to request funding for these six codes so providers will be able to integrate case/care managers support of the Medical Home concept, such as the Medicare Medical Home Demonstration, pay for performance programs, and various collaborative models of care which CMSA and other regulatory agencies are discussing.

For more information about this issue of CPT coding for case management, contact Michel Lee, manager of member and chapter services at mlee@acminet.com or call (501) 225-2229, ext. 1120. ■

(Continued from page 70)

because they were not homebound.

"We felt that we were missing an educational opportunity with these patients. We asked our hospital administration if the hospital could support one follow-up visit by a home health nurse for patients whose insurance didn't cover home health services," she says.

Now, the care coordinators schedule a home visit 24 to 48 hours after the patient is discharged.

If patients qualify for home care, the hospital gives them a list of agencies to choose from in order to meet the Medicare conditions of participation. If they aren't covered for home care, the hospital sends out the home care agency it contracts with.

During the home care visit, the nurse looks at what foods are in the kitchen and educates the patients on which foods are high in sodium and should be avoided. She takes the patients' blood pressure and pulse and does a safety check of the home.

"We think the home visits are a major part of helping patients adhere to their treatment plan. We've found that the best place for medication reconciliation is in the patient's home when they can pull out the shoe box with all their medication in it. The home care staff have found quite a few duplicate medications or learned that patients have not been taking their medication properly," she says.

The hospital has always scheduled follow-up appointments before patients are discharged, but it took a lot of work to convince the attending physician that two to three weeks wasn't soon enough for a visit, Bradke says.

The hospital team members compiled data on readmissions to demonstrate to the physicians what a difference it would make if they saw the patients sooner.

Now, about 80% of patients get in to see a physician within seven days, compared to about 10% to 12% when the initiative started.

"The cardiologists had been taught to automatically set a follow-up appointment in two to three weeks. We worked with them to create a standing order to change the follow-up appointment date if necessary to make sure the patient sees the cardiologist in the first week," she says.

When the initiative began, the team examined the education process and educational materials used by all of the disciplines throughout the continuum of care.

"It was evident from our review of the materials that every person who educated the patients did something different. The information patients got in the hospital wasn't the same as what the home care staff gave them and could be different from the information they received in the clinic," she says.

The cross-continuum team began working on developing educational materials in February 2006, and over the next nine months had the materials reviewed by patients and family members, then tweaked them based on patient and family suggestions.

The family member participant on the heart failure team shared the materials with her siblings. The team presented the materials to several sessions of the hospital's outpatient heart failure class to find out if they understand the materials and to get their input.

"As a system, we were doing a lot of education on health literacy and beginning to implement patient- and family-centered care. We incorporated this into our heart failure education initiative," she says.

"What has made this initiative so different is that we are listening to the voices of the patients and the family members. We wanted to tailor the program to do what is best for the patient, and the best way to do that is to get their input on what will make a difference," she adds.

The team worked on consistent education and created a simple and easy-to-understand packet of information to replace the piles of paper patients had been receiving.

The team designed a 5 x 7-inch refrigerator magnet with the warning signs and symptoms of heart failure that should be reported to the physician.

"Our patient educational materials have been redesigned to include only the essential information. We give patients a magnet and a one-page sheet that describes the pathology and physiology of heart failure in words they can understand," she says.

The hospital calls its nutritional hand-out an "Eating Plan" rather than a diet plan. The document is written in simple language, with lots of pictures.

"When the representatives from the long-term care facility and skilled facilities reviewed the packet of information, they reported that they would find our educational information useful in treating the patients we refer to them," she says.

The representatives from the post-acute facilities asked for the magnets to hang in patient rooms above the scales to continue the educational process as the patient was being treated.

"We found that it's the little things, like the

magnet, that make a big difference," she says.

The cross-continuum team incorporated the teach-back method into the patient care delivery at all levels of care.

"Teach back" means asking patients to repeat in their own words what you have just taught them to make sure they completely understand it.

The team came up with four teach-back questions that staff in the hospital, the clinic, and home care all use in their patient education:

- Do you know the name of the water pill you were prescribed?
- Do you know the signs and symptoms that mean you should call the doctor?
- Do you know what foods to avoid?
- Do you know what weight gain you should report to the doctor?

The hospital has published a calendar for heart failure patients with spaces for the patients to log their weight each day, health tips for each month, and times and dates of the hospital's heart failure classes.

"The calendars are very popular. Patients who haven't been in the hospital for a while call and ask for them," she says.

The hospital's cardiac rehabilitation nurse and dietician have presented heart failure classes to the staff at nursing homes and long-term care facilities.

"The staff in these facilities are generalists, and they can't keep up with everything. The facilities welcomed us and sent their nurses, their certified nurse assistants, and even their dieticians to the classes," Bradke says.

The hospital also offered the classes to all the home care agencies in the area.

The team has developed a new transfer form for patients going to long-term and skilled nursing facilities. In addition, the care coordinators make a verbal report to their counterparts at the facility to emphasize patient care needs.

The team continues to meet regularly to analyze readmissions and look for things that could have been done differently to prevent the patient coming back.

"In the hospital, we look at the information that we are getting upfront from the patients. If they are readmitted, we ask patients in their own words what brought them back, compare it to what the doctor says, and incorporate that into our education," she says.

When the initiative started, the team met weekly, then cut back to every two weeks , then monthly.

Now, the team is meeting every two weeks and looking at coordination of care throughout the continuum for patients with chronic obstructive pulmonary disease and pneumonia.

The hospital added family members, a respiratory therapist, and a nurse from a pulmonologist clinic to this team.

Building relationships with post-acute providers is a good way to improve patient care throughout the continuum, Bradke says.

In the past, she called long-term care facilities to ask how the handoffs from the hospital were working.

"We got glowing reviews. After all, we're their customer and they weren't likely to tell me any complaints over the phone when they didn't know me. Now that we've built that relationship, it's easier for them to call us when we have a poor handoff. Then we can work together to make it better," she says.

(For more information, contact: ***Peg Bradke****, RN, MA, heart care services director, St. Luke's Hospital, e-mail: BradkeMM@ihs.org.)* ■

ACCESS MANAGEMENT

QUARTERLY

Don't miss a chance to collect

Do you have the technology, processes you need?

Lack of the right technology to automate time-consuming, error-prone processes can put patient access departments at a big disadvantage. On the other hand, there is a concern that some technology investments may be a waste of money, particularly when all expenditures are being put under the microscope.

"Collecting cash at the point of service is not the taboo topic it once was," says **Ron Camejo**, director of revenue cycle practice at Chadds Ford, PA-based IMA Consulting. "This is partly due to a growing realization of the importance of upfront collections to an organization's bot-

tom line, and partly due to the emergence of technology 'accelerators' that are simplifying the once-onerous task."

After implementing stand-alone applications, some patient access department are seeing impressive results. However, Camejo says when these are implemented as "components of a well-considered revenue cycle vision, the overall results can be greater than the sum of individual parts."

John Woerly, RHIA, CHAM, a senior manager at Accenture in Indianapolis, says that these technologies should be considered by patient access leaders in order of importance:

- insurance eligibility/benefit verification tools;
- an online benefits engine, which ties employer/payer information to managed care contracting;
- patient liability estimation tools;
- point-of-service collection tools;
- propensity to collect/credit scoring tools;
- online outstationed Medicaid eligibility screening;
- application production tools, online charity application screening, and application production tools.

"Potential technology disasters include non-integrated, stand-alone systems — systems that have limited payer connectivity, poor vendor implementation planning, and [are] not fully monitoring outcomes," says Woerly. "You need to be looking at results on a daily basis and reporting and tracking results."

Woerly says planning, training, and monitoring are the ways to avoid these pitfalls. "Measure current outcomes with denials, upfront collections, the number of Medicaid referrals and approvals, and number of charity cases approved," he says. "Know the full cost of the system change, including the impact on staffing, and the per-transaction cost vs. an annual flat rate."

Don't depend on vendors

Kristi Heussy, revenue and billing system manager at Virginia Mason Medical Center in Seattle, says that when reviewing a potential technology investment, she answers these questions: Will it fit with our flow? Will it benefit our patients? Will it give a good return on investment?

Heussy says that one mistake is to place too much dependence on an outside vendor, instead of working as partners. "The key for partnering is making sure you and the vendor have the same vision for what constitutes a good

CNE questions

17. Visiting Nurse Services of New York reports that after it collaborated with one hospital to reduce readmissions for heart failure patients, readmission rates dropped by what percentage?
A. 20%
B. 28%
C. 36%
D. 41%

18. According to Cory Sevin, of the Institute for Healthcare Improvement, what percentage of patients doesn't understand what to do after discharge?
A. 60%
B. 50%
C. 40%
D. 30%

19. During what time period are patients at the highest risk for readmission to the hospital?
A. The first week after discharge
B. 10 days after discharge
C. 30 days after discharge
D. Two months after discharge

20. St. Luke's Hospital in Cedar Rapids, IA, schedules a home health visit for all heart failure patients in what time frame?
A. Within a week after discharge
B. The day after discharge
C. Within 24 to 48 hours after discharge
D. Within 36 to 72 hours after discharge

Answer key: 17. D; 18. B; 19. A; 20. 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 June issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

outcome," she says. For example, if a vendor is tasked with completing a coverage application for a patient, for them a good outcome is getting that work done. For the medical center, though, the good outcome is getting the patient coverage so that he or she may get safe, effective treatment and discharge, as well as payment for services provided.

Before investing in any patient access technology, Heussy says that you must do some upfront work in your department, as follows:

• Involve staff in improvement work, such as eliminating waste and improving flow.

• Understand who your upstream and downstream customers are. "Interview all parties to determine who is a customer of the service to ensure every aspect of the work is covered and sequenced," says Heussy. "Do not depend on a vendor to solve a problem that is deeply embedded in the flow of information in the hospital."

• When talking with other users, ask detailed questions about the format of electronic information being returned.

• Take the time to do site visits of the vendor's other customers. "It's helpful to see how other customers are using the product successfully," says Heussy.

A. James Bender, MD, Virginia Mason's medical director of health information, says, "Access, and the systems that support it, need to be focused on the patient's needs, and efficiently gathering the clinical, social, referral, and financial information that is needed for timely care and defect-free billing. The goals are seamless integration, first call resolve, and high reliability."

The information gathered at the time of a request for service is a "set up" for closure of the encounter. "The ideal system prompts the capture of information as data in a 'reusable' format as we build the patient's story. We avoid the waste and errors of duplication and then present this information where it is needed throughout the episode of care," says Bender. "In our vision, care begins at the request for service and ends when the medical interaction is complete and the bill is paid."

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Revamp access with these 10 technologies

"A number of exciting collection technologies have evolved over the last few years. They are already lowering costs and improving services," says **John Thompson**, senior consulting manager at Chadds Ford, PA-based IMA Consulting. Here, he gives his "top 10 list" of patient access technologies:

1. Contact verification.

In addition to improving billing and statement delivery, this can also increase staff productivity. "Optional batch features are often offered," says Thompson.

2. Eligibility verification.

Coverage benefits can be verified prior to service delivery by submitting patient information and receiving a real-time response. "Rejections and denials are reduced, and upfront collections are increased," says Thompson. While old approaches for web site and telephone verification weren't integrated, key features to look for now include normalized benefit formats with the ability to design "standard" and "detailed" benefit screens, and ADT/practice management system integration.

3. Patient payment estimation.

These systems can reduce bad debt, accelerate payments, and cut collection costs. Previously, staff collected only copayments and self-pay deposits, and these were based on "guesstimates rather than estimates," says Thompson. New systems have charge master/eligibility system integration, with the ability to apply benefits to real charges, and charge master/contract management

integration, with the ability to apply contractual allowances before developing estimates.

4. Communication management.

Having electronic records of payer communications can increase productivity, reduce denials, and increase successful appeals. Thompson says that features to look for include the ability to automate and monitor calls, and manage inbound and outbound faxed documents and e-mails.

5. Propensity-to-pay scoring.

This streamlines self-pay approvals while proactively identifying the need for financial assistance, instead of subjective approvals done by financial counseling staff. "This resulted in understated charity care on financial sources," says Thompson. New systems are able to factor in self-pay funding sources, such as available credit on credit cards, lines of credit and home equity, and external finance solutions offered by banks and other lenders.

Thompson says two good features are segmentation analysis, which customizes scoring profiles to community characteristics, and workflow management, which electronically forwards accounts to the financial counseling process.

6. Electronic cashiering.

This can accelerate collections by increasing the speed of payment capture, save time by automating manual payment posting, and increase efficiency by enabling more employees to accept payments. "It also provides dashboard reporting of payment activity, with the ability to track, audit, and control all customer payments," says Thompson. Instead of collecting payments only at the time of service, these can be accepted real-time from any location, including web portals. Thompson says to look for a system that accepts all forms of electronic payment and does cash posting and management so that payments can be audited, tracked, and controlled.

7. Financial assistance automation.

A patient's eligibility for entitlement programs is proactively identified, which reduces unnecessary outsourcing to self-pay vendors and cumbersome manual processes. Systems can pre-populate applications for Medicaid with information from your ADT system. "Look for integration with propensity-to-pay systems and e-pay systems, and presumptive eligibility and approvals," says Thompson.

8. Rule-based document imaging.

These systems can reduce time-consuming copying and scanning, and there are fewer denials related to missing referral or authorization forms. "Optical character recognition mapping compares insurance card information to ADT system fields

CNE OBJECTIVES

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

- identify the particular clinical, administrative or regulatory issues related to the profession of case management
- describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the health care industry at large
- discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

COMING IN FUTURE MONTHS

- How to prepare for Medicare's reimbursement changes in fiscal year 2011
- Case management in long-term acute care hospitals
- Tips for preparing for a RAC audit
- Ethical issues that confront case managers

and corrects data entry errors," says Thompson.

9. Patient self-service kiosks.

These can reduce wait times and decrease errors due to inconsistent collection compliance. Thompson says to look for a system with date/time stamping of arrival, automated printing of armbands, and real-time payment processing and eligibility verification.

10. Rule-based process automation.

"Efficiency can be vastly increased, cash flow and collections improved, and whole categories of errors eliminated," says Thompson. "Look for full integration between all applications." ■

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