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IPPS final rule means hospitals must do more with less

Pressure, responsibilities may increase for case managers

The inpatient prospective payment system (IPPS) final rule, issued by the Centers for Medicare & Medicaid Services on July 30 makes it clear that the health care agency expects hospitals to do more with less reimbursement.

In the final rule, the annual market basket update increase of 2.35% is offset by a 2.9% documentation and coding adjustment, resulting in a decrease in payments of 0.4%, or a total of $440 million for hospitals throughout the country.

The final rule also clarifies changes to the three-day payment window as mandated by Congress in legislation passed June 25, 2010, and requires hospital staff to determine whether outpatient therapeutic services are clinically associated with the inpatient admission. Another provision in the final rule adds 10 quality measures to the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) set and retires one measure — mortality for selected surgical procedures.

The documentation coding adjustment, which cuts reimbursement, makes it important for hospitals to place great emphasis on compliant and effective clinical documentation in order to receive all the reimbursement to which they are legally entitled. This may mean increased responsibilities for case managers, says **Susan Wallace**, MEd, RHIA, CCS, CCDS, director of inpatient compliance for Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK.

"In addition, CMS specified in the final rule that clinical decision-making will be involved in determining whether the outpatient services should be combined with the inpatient bill. That role could potentially fall to case managers," adds **Deborah Hale**, CSS, CCDS, president and CEO of Administrative Consultant Services.

The details contained in the IPPS final rule mean that hospitals are going to get less money from Medicare, which means that they are going

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to have to increase efficiency and effectiveness in order to survive, adds **Quint Studer**, CEO of Studer Group, a health care consulting firm based in Gulf Breeze, FL.

Many times, when faced with challenges, hospitals look at changing their strategy and structure; but in order to do more with less reimbursement, hospitals have to look at improving efficiency, and case managers can be a central figure in the process, he adds.

Case managers are in the position to be a leader in the hospital's initiatives to improve clinical outcomes, to increase efficiency and effectiveness, and to maximize resources, Studer says.

CMS included the 2.9% documentation and coding adjustment in the final rule despite strong opposition from the hospital community.

"America's hospitals strongly disagree with the Centers for Medicare & Medicaid Services' final inpatient rule. The rule cuts billions of dollars from the health care system at a time when patient are sicker, more people are losing coverage due to the economic downturn, and hospitals are dealing with significant changes contained in the health reform bill," Rich Umbdenstock, president and CEO of the American Hospital Association, said in a statement.

"In issuing the final rule, CMS failed to acknowledge independent studies that show CMS' methodology does not take into account what we all know: Hospital patients are increasingly sicker," he adds.

CMS says in a statement that the increased payments following the adoption of the MS-DRG system did not reflect actual increases in patients' severity and that the reimbursement adjustment is intended to eliminate the effect of coding or classification changes that CMS feels do not reflect real changes in case mix.

The adjustment is mandated by legislation passed in 2007, which requires CMS to recoup the entire amount of increased spending that occurred in fiscal years 2008 and 2009 as a result of the adoption of the MS-DRG system.

The adoption of the MS-DRG system was intended to be budget-neutral, but the Medicare Actuary estimates that the cumulative effect of the documentation and coding increased spending by 5.8% in fiscal years 2008 and 2009.

By law, CMS must recoup excess spending by fiscal 2012. The agency announced its intention to further adjust reimbursement by 2.9% in fiscal year 2012.

CMS is using changes in payment structure as a measure to force hospitals to become more efficient and effective, Studer says.

"The government has no tool other than money that it can use to increase efficiency and effectiveness and lower health care costs," he adds.

The final rule doesn't make many changes in the proposed IPPS rule CMS issued earlier this year,

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Wallace says.

The biggest change is further clarification of the three-day payment window as mandated by Congress in a section of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010.

The final rule clarifies a section of the act passed by Congress, regarding Medicare's three-day payment window, also called the "72-hour rule," which sets out which diagnostic and non-diagnostic outpatient services must be bundled into the bill for the inpatient stay.

The new law continues the Medicare policy that all diagnostic services, including diagnostic laboratory tests, that occur on the day of admission and the three calendar days prior to the admission be included in the bill for the inpatient stay if they are provided by the hospital or an entity that is wholly owned or wholly operated by the hospital.

The act specifies that all non-diagnostic outpatient services (other than ambulance and maintenance renal dialysis) that are provided by the hospital or a wholly owned or operated entity on the date of the inpatient admission must be billed as part of the inpatient stay.

The law also stipulates that all other non-diagnostic services provided by the hospital or its wholly owned or operated entity in the three calendar days preceding the admission must be bundled with the bill for the inpatient stay if they are related to the reason for the admission.

If they are unrelated to the admission, the hospital may separately bill Medicare Part B.

Congress left it up to CMS to create a definition for services related to the inpatient stay.

In the IPPS final rule, CMS issued a definition of services related to the inpatient stay, declaring that an outpatient service is related to the admission if it is clinically associated with the reason for the admission.

However, rather than requiring hospitals to bill only services clinically related to the stay, CMS specified that all outpatient non-diagnostic services on the three calendar days before the inpatient admission must be billed with the inpatient stay unless the hospital attests that the preadmission services are clinically distinct and independent from the reason for the admission.

The rule also specifies that the patient's medical record must contain complete documentation as to why the services are unrelated. In addition, CMS announced its intention to review separately billed outpatient services.

Before the changes in the rule, hospitals could bill separately for any therapeutic service provided within the three-day window, if it was unrelated to the reason for admission. The CMS definition of "unrelated" at that time meant that the 5-digit ICD-9 codes were not the same, Wallace says.

That means that if the ICD-9 codes did not match exactly, the hospital could bill separately for the therapeutic services.

For instance, if a patient came in for an outpatient procedure and then required inpatient admission for cardiac arrhythmia, the hospital would bill Medicare Part B for the outpatient procedure and bill for inpatient services related to the arrhythmia because the ICD-9 codes were different.

On the other hand, if the patient received an outpatient procedure and experienced minor signs and symptoms (such as nausea, vomiting, and pain) that were associated with the procedure, and the surgeon wanted to admit the patient, the hospital would bundle the services because the hospitalization was related to the outpatient procedure and both the reason for the procedure and the reason for admission were represented by the same ICD-9 code.

Originally, it was the coders who were major players in determining if the services could be split into two bills because they are the ones familiar with the ICD-9 codes, Wallace adds.

When the Recovery Audit Contractors began looking at hospital records, they pointed out that hospitals were bundling some services that could have been billed separately. At an open door forum, CMS said that it was legal to split the bills and that hospitals could go back and break out the outpatient services and rebill Medicare.

When the CMS Medicare Administrative Contractors were flooded with new claims, this prompted Congress to include legislation in the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 prohibiting Medicare from reopening a claim or adjusting a claim that was not submitted prior to June 25, 2010.

The final rule adds 10 quality measures that hospitals must report in order to receive the full market basket update and retires one measure, mortality for selected surgical procedures. In the proposed rule, CMS announced its intention to add 45 measures but backed away from adding registry-based measures at this time.

Of the 10 additional quality measures, eight of the 10 categories of hospital-acquired condition measures will be considered in determining the hospital's update for fiscal year 2012. These

include foreign objects retained after surgery, air embolism, blood incompatibility, pressure ulcer Stages III and IV, falls and trauma, vascular catheter-associated infection, catheter-associated urinary tract infection, and manifestations of poor glycemic control.

The remaining two measures to be reported in 2011 and considered in determining the hospitals' fiscal year 2013 update, are post-operative respiratory failure and post-operative pulmonary embolism or DVT.

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Throughput plan includes department redesign

Patient flow office gets admission status up front

Before patients are admitted to Intermountain McKay-Dee Hospital, a patient flow nurse completes the first level of review for medical necessity and works with the admitting physician to determine the patient status.

"Our philosophy is that if we get the status right upfront, the downstream effect is minimized. If we get the patient status wrong, there's a lot of work that has to be done to correct it," says **Charlotte Foy**, MSN, RN, director of quality and case management at the 299-bed hospital.

The process was developed as part of the hospital's initiative to improve patient throughput by getting patients into the right type of bed under the right status and moving them along the continuum in an efficient and effective way,

"Our multidisciplinary team analyzed all aspects of the patient stay, beginning with how patients come into the hospital and looked at the most effective way to get patients in the right status once it was determined that they need to be placed in a bed. We recognized early on that this is a process that can't be owned by case management and social work alone," Foy adds.

The team created the new patient flow department, which is the main hub for all patients admitted into the facility except for those being admitted into labor and delivery and the psychiatric floor.

The office is staffed by patient flow nurses who are on duty 24 hours a day, seven days a week. Their only job is to assign beds and conduct medical necessity reviews. They are assisted during regular business hours by patient flow specialists who handle the clerical work.

"The patient flow nurses are like air traffic controllers. They use an electronic bed board that is color-coded and tracks patients from the time we first get an order for a patient to be admitted through discharge," Foy says.

When a patient is to be admitted, the patient flow office is alerted of the physicians order for admission and status. The patient flow nurse accesses the patient's medical record, conducts the first level of review for medical necessity, and works with the admitting physician to determine the patient status.

If the patient flow nurse doesn't agree with the order for level of care, he or she calls the physician and requests additional clinical information to support the level of care the physician ordered.

"They come to a consensus and the bed flow nurse lets the admissions clerk know the bed in which the patient will be placed," she says.

If the physician and nurse cannot agree on the level of care, the patient flow nurse admits the patient as ordered by the physician and refers the case to the physician advisor for review.

The hospital worked with a consulting firm on patient flow initiatives and in the process redesigned the case management model.

In the old model, staff called quality managers handled the case management and quality nurse tasks. They reported to the directors over their services, with the exception of the quality managers on the medical and surgical units, who reported to the case management director.

Now, all case managers and social workers report to a central manager. The case managers, who had been service-line based, became unit-based and are assigned to a number of beds in a unit depending on the severity of the patients.

Case managers and social workers cover the units and the emergency department Monday through Friday. Social workers work on weekends and holidays and are on call after business hours.

Before the patient flow project, the hospital did not have a case management documentation sys-

tem. As part of the redesign, the department began using case management software that interfaces with the computers in the patient flow office and admitting and registration.

"We charted in the electronic medical records, but the system didn't allow us to pull reports. Now we have software that we can use to document everything we do, track trends, and conduct quality reviews," she says.

As the patient is admitted, the electronic registration system interfaces with the case management and social work system and triggers an activity work list for the social workers and case managers on that unit. The work list identifies various tasks ranging from insurance reviews to discharge planning.

Each patient is assigned a social worker and a case manager who work as a team.

"The social workers and case managers each have unique roles and middle ground where they can fluctuate back and forth depending on the needs of the patients and the needs of the unit," Foy says.

For instance, the social worker typically handles all psychosocial assessments while the case manager is the team member in charge of utilization review and regulatory issues. They both share discharge planning depending on the type and needs of the patient.

On admission, patients and family members complete a history form, which the nurse reviews and alerts social workers if there are discharge needs. Social workers conduct an initial screen within 24 hours of admission, assessing psychosocial and discharge needs.

The case managers look at all admissions each day and review the admissions status determined by the patient flow nurse. Patients with outpatient status who are receiving observation services are reviewed every day by the case manager.

"Our goal is to get patients in outpatient status either discharged appropriately or admitted as an inpatient within 24 hours if their condition warrants the change," Foy says.

Every unit in the hospital has a daily care coordinating meeting attended by the bedside nurse, the charge nurse on the unit, the case manager, the social worker, and other members of the interdisciplinary team when appropriate. Hospitalists attend when they are treating patients on the unit.

The team looks at why the patient was admitted, his or her progress, what needs to be accomplished before discharge, and the patient's discharge needs, with team members taking responsibility to see that the patient's needs are met.

Each patient room has a white board on which the team writes the goals the patient needs to meet before discharge and a tentative discharge day.

Within 24 hours after a patient is admitted, the bedside nurses and the rest of the team select an anticipated discharge date, enter it into the medical record and monitor it.

During the admission process, the staff talk to patients and their family members about who will transport the patient home, what kind of help they will need, and determine if they have transportation.

All the case managers and social workers attend weekly clinical high-risk meetings to discuss patients who are exceeding their expected length of stay, those whose cost of care has reached a high level, and those who have roadblocks to discharge.

The meeting is attended by representatives from insurance verification and the eligibility office.

The case management software system triggers patients who need to be discussed in the meeting. The case managers fill in additional information that helps the team determine the best steps to take.

"It's a great opportunity for the entire staff to meet and solve problems," Foy says.

For instance, if there is a patient on the surgical floor who is not progressing and who is fearful of going home, the psychiatric case manager may suggest a psychiatric evaluation or that the patient be discharged to a particular skilled nursing facility that has staff skilled in treating psychological problems.

It took about six months for the hospital to develop the patient flow initiatives, train staff, and switch to the new process.

"We had a great team working on it. We had daily huddles at noon every day and talked about what was going right and what was going wrong," Foy says.

To ensure that the patient flow process continues to run smoothly, the hospital's department directors meet once a week for a patient progression meeting.

The directors look at a variety of patient flow measures including how long it takes to transport patients to a bed once the bed is ready, how long it takes for the room to be cleaned once it's ready, and the length of time between when the discharge orders are signed and the patient is out the door.

"We've taken a team approach to our efforts to

improve patient throughput. It wouldn't have been so successful if we just focused on case management and social work. Our conjoined effort has involved environmental services, the nursing staff, the clerical staff, and physicians. It's been a big change," Foy says.

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Palliative care team, CMs help patients

Approach can decrease LOS, patient throughput

When Integris Baptist Medical Center in Oklahoma City began looking at implementing palliative care and end-of-life services, the case management department was the appropriate place to start, says **Anita Bell**, RN, MEd CHPN, palliative care coordinator at the 508-bed facility.

"There are so many similarities between palliative care and case management. Hospital case managers are constantly challenged to decrease the utilization of hospital resources and length of stay while maintaining quality care. Studies have shown that palliative care can decrease the cost of hospitalization and improve a patient's quality of life by advocating for care in the most appropriate setting," Bell says.

In addition to Bell, the palliative care team includes a chaplain, the medical director, a social worker, a pharmacist, and a nurse who does healing touch.

"We've done some research, and healing touch has been able to show a decrease in pain and anxiety," Bell says.

The team is assisted by volunteers who handle data entry and make comfort care shawls that the palliative care team or nurse give to patients or family members, depending on the situation.

Case managers can see the big picture within the hospital and often are the first clinicians who identify patients who might benefit from palliative care services, Bell says.

"Because of the case managers' focus on setting goals with the family, educating them, and looking at their discharge needs, they are instrumental in making sure we meet with patients and families who need palliative care services," she adds.

Palliative care and case management have mutual goals: decreasing length of stay and ensuring that patients receive the care they need at the right place in the continuum, Bell says.

"Many times when patients have problems with pain or symptom management, they have a longer length of stay as the hospital staff try to get the problem under control. Palliative care helps with pain and symptom management, which can improve patient throughput and length of stay in the hospital," Bell says.

Case managers often call in the palliative care team for help in working with patients and family members to understand their options and to set goals of care for the patient, she adds.

"The case managers will say to me that the physicians have talked to the patient and family but they need more help understanding how ill the patient is and options for care. The palliative care team can go in with the doctor's permission and help educate the family and support them as they make choices," she says.

Patients who could benefit from a palliative care consultation often are identified during discharge planning rounds, says **Suzanne Creekmore**, RN, CCM, case manager for the med/surg intensive care unit and the intermediate care unit.

The discharge planning rounds in the ICU are attended by the case manager, the social worker, the nurse taking care of the patient, the chaplain, the ICU clinical director, the palliative care coordinator, and representatives from dietary, pharmacy, and other disciplines and departments if needed.

The team goes through each patient, one by one, starting with the diagnosis, the family support, and the goals for the day, along with individual details such as use of pain medication, ventilator length of stay, psychosocial or family issues.

The team discusses the plan of care and the discharge plan and looks at options if the patient isn't able to go home.

For instance, if a patient has a stroke, is not responding, and isn't likely to recover, the team may call Bell in to help the family through the grieving process.

Bell also may be called in if patients have a lot of pain that isn't being controlled with IV pain medication.

"We want to help the patients have better control of their pain for whatever time they have left, whether it's a matter of months or years. Some patients aren't ready for hospice and want to keep

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CRITICAL PATH NETWORK™

Systemwide HF program decreases readmissions

Collaboration among all levels of care key to success

A systemwide initiative that coordinates care across the continuum for heart failure patients has reduced the 30-day readmission rate for the North Shore-LIJ health system.

"Heart failure is a chronic condition that affects about 6,000 patients in our system every year. Coordinating care for this chronic condition is imperative to reduce avoidable readmissions," says **Karen Nelson**, RN, vice president of clinical excellence and quality for the metropolitan New York City health system.

The health system has created a three-year strategic plan for clinical excellence and quality that is aligned with the National Quality Forum's national priorities. One area of focus is reducing 30-day readmissions for patients with heart failure.

The strategic plan "began to clearly articulate the quality imperatives, actionable initiatives, and measures of success for the health system," Nelson says.

The health system was presented the National Quality Forum Healthcare Award for its ongoing commitment to providing high-quality, transparent, and patient-centered health care.

The heart failure process redesign was undertaken by a task force made up of representatives from 14 hospitals, two long-term care facilities, five home health care agencies, ambulatory care, and the health system's hospice network.

"A strong emphasis was placed on transitioning patients to the next level of care and enhancing information flow among care providers, patients, and their families/caregivers," Nelson says.

The task force includes full-time and voluntary community physicians, nurse practitioners, nurses, social workers, case managers, nutritionists, representatives from quality management, administration, pharmacy, and procurement as well as representatives from the health system's hospice, subacute and long-term care facilities, and home care agencies.

"The heart failure program was prioritized by clinical and administrative leadership throughout the organization," Nelson says.

A physician and a nurse co-chair the task force.

"The first objective was to agree on best practices as identified in evidence-based research and to explore successful initiatives in other institutions," says **Geraldine Koster**, RN, director of operations for the institute of clinical excellence and quality.

The task force identified four distinct phases of care and established subcommittees for each phase: emergency department, inpatient, discharge, and post-acute.

The subcommittees developed flow charts and diagrams to help identify barriers to effective and efficient care delivery and opportunities to enhance care coordination and communication handoffs.

"We challenged the clinicians on the subcommittees to come up with specific ideas to improve communication among the phases of care and to report back to the task force. There was a lot of discussion and consensus building during the process," she says.

The task force used the suggestions from the subcommittees to develop tools that bridge gaps in care and ensure consistency throughout the treatment process and throughout the health system.

The team developed tools such as diagnostic and treatment algorithms, admission order sets, and a discharge pathway, all of which incorporate evidence-based care. The team developed patient and family teaching materials that are used consistently throughout the organization. Since English is not the primary language for many patients, the

educational materials were translated into multiple languages.

The heart failure tool box and evidence-based care delivery are standardized systemwide, but the individual facilities determine how they will implement them, Nelson adds.

For instance, some hospitals have designated heart failure nurse practitioners or other mid-level providers to coordinate the care of heart failure patients. Others use case managers, clinical care coordinators, and discharge planners in the care coordination role.

The heart failure task force continues to meet once a month using data to review performance and shares best practices and lessons learned across the health system.

"When we started this process, everyone agreed that the program would be initiated and modified as needed after implementation throughout the system. Any part of the process that was working as expected would be revisited," Nelson says.

The heart failure program starts in the emergency department where the team identified variations in treatment, Koster says.

The emergency department staff were educated on the evidence-based treatment for heart failure, and the task force subcommittee developed an algorithm for treating heart failure.

"It's an ongoing process. Hospitals have established concurrent monitoring to ensure that the algorithm is being followed," Koster adds.

Multidisciplinary heart failure teams at each site conduct rounds on heart failure patients to ensure compliance with evidence-based care.

The clinical team works with the patients and their caregivers to develop a plan of care that takes into account the severity of the patient's condition, support from family members, and other psychosocial issues.

All patient information including the plan of care, dietary requirements, and medication is available to providers at every level of care through the health system's electronic system, Nelson says.

A key to the success of the initiative is multidisciplinary rounds at each hospital, which may include, but are not limited to, physicians, nurse practitioners, physician assistants, nurses, case managers, and social workers; the mix can vary depending on the hospital.

Part of the challenge is that heart failure patients are not always in the same unit. The attending physician may be a cardiologist, a hospitalist, or an internist.

"This is why the team approach and rounding is so important," Nelson says.

The discharge planners begin the discharge process when the patient is admitted. They conduct an assessment of the patient's needs for support after discharge and when, appropriate, make a referral for home care services within 24 to 48 hours of admission.

Clinicians from each hospital in the system make post-discharge telephone calls to heart failure patients 24 to 48 hours after discharge and make weekly follow-up telephone calls for six weeks.

The person making the follow-up phone calls varies from site to site, depending on the resources at each facility, but the calls always are made by a clinician. In some hospitals, the case managers make the calls. One hospital uses the post-anesthesia care unit nurses to make follow-up calls early in the day, Nelson says.

During the weekly phone calls, the clinicians assess the patient's progress, ask about diet, weight, and medication compliance, and educate the patient when needed.

"We found that many times, patients are confused about their medication once they get home. Even though they received discharge instructions in the hospital, they go home to a cabinet full of medications and are not clear as to which medications they should be taking," Koster adds.

Several patients have been identified as having early signs of exacerbation of their condition during the post-discharge telephone call.

Case managers and other clinicians have been able to identify patients who are short of breath or have gained weight and have instructed them to contact their physician.

At present, the clinicians make phone calls only to patients who have been discharged to home.

"Expanding the calls to include patients discharged to another facility is an opportunity for the future and will require facilitation on a facility-by-facility basis," Nelson says.

The teamwork has facilitated direct communication between the discharge planners and home care services, Koster says.

"When we discharge our patients to North Shore-LIJ home care and subacute or long-term care facilities, we have enhanced communication because we have worked together on this initiative," she adds.

"Hospitals have reached out to their local nursing homes and subacute facilities to foster relationships, provide education, and enhance communication transfer with the goal of improv-

ing care and working together to reduce heart failure readmissions," Nelson adds.

Depending on the wishes of the receiving organization, the discharge planner provides written information or telephones the next provider with patient information.

The heart failure team developed a universal teaching booklet that is being used across the entire continuum, Koster says.

The "Be in the Know" pocket guide to heart failure includes signs and symptoms patients should look for and when they should contact their physician.

"We are sending a consistent message and giving the patients materials they can recognize. They receive the same booklet and instructions whether they're in the outpatient setting or being discharged from the acute care hospital," she says.

In addition, the hospitals give scales to patients who do not have one and encourage them to weigh themselves every day and to call their doctor when they experience unusual weight gain.

The team tracks readmissions and analyzes the data to determine if any processes need to be refined.

For instance, at one site, if a patient is readmitted and was under the care of the North Shore-LIJ home care, the nurse at the hospital and the home care nurse are in direct contact to assist in determining what might have lead up to the readmission and to address opportunities for improvement in the future.

"If a patient is readmitted within 30 days, it triggers an extensive readmission review to identify further opportunities to improve the process," Nelson says.

The systemwide 30-day readmission rate for heart failure has gone from 24.9% in 2009 to 19.8% in 2010.

"This downward trend is very encouraging. However, the heart failure program requires constant vigilance and teamwork to continue to achieve success," Koster says. ■

Provide better ED discharge planning

Use resources to assess home environment

The health care system benefits when unnecessary hospital admissions are avoided, and sometimes the best place to impact that trend is by focusing discharge services on the hospital emergency department (ED), an expert says.

"If you can avoid an admission in the hospital, it's good for the patient, as well as for the health care system," says **W. June Simmons**, CEO of Partners in Care Foundation in San Fernando, CA. The nonprofit organization focuses on innovations in delivery-system design through early intervention and prevention.

One way it's good for the hospital is that many patients who use the emergency room for care are the same patients who lack adequate health care resources, as well as community support. So, they might become a compassionate care admission to the hospital, simply because hospital providers do not know where else to send them, Simmons notes.

"Hospital [providers] don't know what to do with these patients and will admit them to the hospital, even though they probably don't need an acute care level of care," Simmons says. "Admitting these patients to an acute care hospital is an expensive and sometimes a risky move for patients, because it's better for people to avoid hospitalization whenever they can."

What are needed are new models for ED discharge and hospital discharge planners who help providers improve these transitions.

"If a social worker could mobilize immediate private duty care in the home, then an ED patient could be discharged home," Simmons says. "Or the hospital social worker could help a patient transfer to a psychiatric unit or some other alternative site."

These types of ED discharge planning need to be explored, she adds.

Hospitals need to look more closely at an integration of community resources and mental health resources when working with care transition of ED patients, Simmons says.

"Some people say 80% of care for chronic conditions occurs in the home, so you have to mobilize the community," she explains. "Transitions are all about making sure someone who has a health challenge or frailty challenge remains at home safely and makes maximum use of the medical care offered to them."

This includes extending hospital/ED discharge planning to environmental assessments. For instance, someone should make certain patients have the necessary wheelchair ramps, elevated toilet seats, and other home adjustments needed to

accommodate someone with limited mobility and chronic health issues.

Patients who are admitted to the hospital after an ED visit, or who are frequent fliers in the ED, often have home environment issues such as an untidy home, improper nutrition, floor tripping hazards, low lighting, substance use, or medication complications, Simmons says.

A hospital discharge planner should know of community resources that might assist with making a home environmental assessment or visit.

Other questions discharge planners should ask about patients are as follows:

- Does the patient have access to food and a safe environment in the home/community?
- Does the patient have transportation to community providers?
- Does the patient have access to medication and any necessary assistance with taking drugs?

This last issue is very important, because older ED patients discharged home often have multiple chronic conditions and a variety of medications to take. Plus, they might have several different doctors who each see only one part of patients' health picture and do not communicate with each other, Simmons says.

Another issue is whether the ED patient has Medicaid or some other payment system that will cover in-home care management.

"The Medicaid waiver is Medicaid with permission to provide ongoing care management in the home," Simmons explains. "You can buy things Medicaid usually doesn't cover like heavy-duty cleaning, putting in ramps and grab bars, and bringing in someone to give the patient a bath."

If patients can't find reimbursement for these services that might make it possible for them to stay at home, then they likely will be ED frequent fliers and end up hospitalized or transitioned to a nursing home for the long term, she adds.

"We've been looking at the Medicaid waiver program in California, and we've found that almost 50% have flagged up on electronic screening for medication alerts," she says. "These patients have signs and symptoms that might reflect a medication problem, including dizziness, confusion, and a history of recent falls."

Half of these patients had a combination of conditions and medications that would suggest the need for a pharmacist to review their medication history, and more than one-third of the patients had medical problems that needed to be brought to the attention of their doctor, Simmons says.

One of the most common problems is therapeutic duplication, in which patients are on three different medication prescriptions, and all of the drugs are in the same class, Simmons says.

"In the Medicaid waiver program, the care manager goes into the patient's home and does a complete assessment, looking at all medications," she adds.

"We developed an electronic system for screening for patients who have concerns, and then a pharmacist reviews these to see if there is a problem," Simmons explains. "So, medication reconciliation is a huge issue in discharge planning."

Discharge planning that spans the hospital continuum, including the ED, likely will be a more common practice as the Patient Protection and Affordable Care Act of 2010 results in philosophical and, eventually, payment shifts in the national health care industry, she predicts.

The Centers for Medicare & Medicaid Services (CMS) has already begun aligning incentives by announcing that it won't pay hospitals for readmissions within 30 days of certain medical conditions, Simmons notes.

Plus, health care reform bill's emphasis on prevention and evidence-based programs will drive a lot of the change.

"There is a whole lot of effort and resources being put into finding better ways of delivering care, and all of these efforts are promising to help us look for something that is more tailored to address where people fall out of the system and close these gaps," Simmons says.

If patients have medical crises, often the root cause of their emergency is related to inadequate discharge planning, she adds.

The goal is to provide rapid follow-up care when patients are transitioned from the ED or hospital to home — and then to assess their situation and follow them closely, Simmons says.

"We need to put the resources in place to keep them stable at home and provide good continuity with their medical care," she adds.

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treatment going, but their quality of life will be better if their pain is under control," Creekmore says.

The case managers often call for a palliative care consultation for people who have chronic diseases, such as chronic obstructive pulmonary disorder, who are not necessarily at the end of the life but are getting worse. In those cases, Bell helps them get advance directives in place before they get really sick, Creekmore says.

"We want to bring the palliative care team in as early as possible to help educate the patient and family members of their options for palliative care and comfort care. Our goal is to get the process started sooner so we can help the patient and family make the appropriate choices at the appropriate time," Creekmore says.

Bell gives the unit an extra set of eyes to help determine the best discharge plan for the patient, Creekmore says.

"Her expertise can help us determine if it would be appropriate for us to discharge the patient to hospice or if he should stay in the hospital and receive hospice care here. She helps us determine how best to approach the family and comfort them," Creekmore says.

When a physician orders a palliative care consult, the case manager and the social worker on the unit accompany Bell as she visits with the patient and family members.

But once Bell gets involved, Creekmore limits her visits with the family.

"If too many people are involved in an emotional situation, it gets to be too much for the family. Once Anita takes over, I back off and go in and talk to the family every day," she says.

When she is called in on a consultation, Bell works with the chaplain, the social worker, the case manager, and physicians to look at pain and symptom management, develop goals of care, help the family do advance care planning, and to support the patient and family if they decide to withdraw lifesaving treatment, move to hospice care, or continue aggressive treatment.

The team can call on a palliative care-certified physician who can meet with patients and help them understand their options.

"When people are in the ICU, so many things are being done for them. The case managers often hear that the patient never wanted that. They call the palliative care team in to talk with the family and clarify the goal of care and what the person wanted," Bell says.

In addition to Bell and the palliative care team, the hospital established the position of palliative care resource nurse on most of the units.

The nurses have other nursing duties but have participated in training on palliative care, keep up with current literature on the subject, and know what resources are available.

The palliative care resource nurses are an added level of expertise on the unit level and are able to identify patients who have more complex needs than what the regular staff can provide and who could benefit from a palliative care consultation, Bell says.

"When families are struggling with trying to make decisions, the palliative care resource nurse knows where to find the information they need. They have a higher training and competency than the rest of the staff. If the family needs more help, they may ask the doctor to ask for a palliative care consultation," she says.

Before establishing the palliative care program, the administration at Integris Baptist researched how the services are provided at other hospitals.

The palliative care process was developed by a committee that included Bell, the case manager director at the time, the director of hospice, and the palliative care medical director, all of whom attended a conference to get ideas for the structures and processes that would work best at Integris Baptist.

"We decided on an approach that embeds palliative care into our culture. We have palliative care resource nurses on most of the units who work along with the palliative care team," Bell says.

The team held in-service education sessions for the hospital's clinical staff and developed written material to educate the staff about palliative care.

In the beginning of the program, Bell worked with the case management team to help them understand how palliative care could be helpful to their patients so they could help inform other members of the treatment team about palliative care and how to identify patients and family members who could benefit from a consultation.

The hospital established a palliative care steering committee to keep the process moving forward. The committee includes the palliative care coordinator, representatives from cardiovascular medicine service, the emergency department, the critical care and neurosciences services, chaplaincy services, pharmacy, social services, hospital medicine services, the ethics committee, and the cancer committee.

Before there was a formal process, most of the family consultations on palliative care and end-of-life issues were done by the social worker or the hospice team was called in, Creekmore says.

"The palliative care team is a wonderful resource that can supplement communication and education provided by the treatment team and help the patients and family members understand their options. Heath care is so fragmented and patients and families are often overwhelmed with the disease process. All of us want to relieve suffering and improve the quality of life for our patients and family members," Creekmore adds.

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Keep patients' blood sugar at normal levels

Initiative aims to shorten LOS

With its approach to glycemic control, SMS St. Mary's Health Center in St. Louis, aims to shorten lengths of stay and "break the cycle of the revolving hospital door," for patients with diabetes as a primary or secondary condition, says **Philip Vaidyan**, MD, head of the IPC academic hospitalist program.

A multidisciplinary team worked with **Reza Rofougaran**, MD, an endocrinologist in private practice to develop a protocol to keep blood sugar levels under control for all patients, even during short hospitalizations, and to ensure that patients without insurance get their prescriptions filled and have a follow-up visit.

Before the protocol was instituted, the average blood glucose level among patients with diabetes in the intensive care was 180 mg/dl. Last year, the average was between 120 mg/dl and 130 mg/dl. Patients with diabetes on the medical/surgical units have an average blood glucose level of 140 mg/dl. About 90% of patients are within the blood sugar goal established by the treatment team.

"Everyone on the hospitalist team realized that there is a problem with inpatient management of diabetes. The mentality at many hospitals has been to practice reactive glucose control when patients are hospitalized for other problems. When patients are in the hospital only two or three days, the practice has been to avoid additional treatment unless the blood sugar level is above 300 mg/dl. We knew we had to change that mentality at our hospital," Rofougaran says.

About 65% of patients with diabetes admitted to St. Mary's already have been diagnosed. The remainder are diagnosed with diabetes while they are in the hospital.

Controlling a diabetic's blood sugar level is important because having blood sugar that is out of control slows the healing process and can increase mortality for surgical, stroke, and heart attack patients, as well as those with infections, such as pneumonia, Vaidyan says.

"We know that if patients with diabetes have an infection and their blood sugars are high, their white blood cells will not work to fight the infection. Wounds are not going to heal when blood sugars are greater than 180 mg/dl. Keeping diabetes under control is important for healing and for helping avoid complications. This in turn helps keep patients off ventilators, out of the intensive care unit, and lowers the length of stay," he adds.

When patients with diabetes are hospitalized, treating the diabetes must be a top priority along with treatment for the medical problem that resulted in the hospitalization, Rofougaran says.

"Patients who have good glycemic control while they are in the hospital have a shorter length of stay than patients with high blood sugar," he points out.

The diabetes initiative was developed by a multidisciplinary team that included nurses, case managers, and pharmacists in addition to Rofougaran, the hospitalist team, and the hospital's certified diabetes nurse educators, Vaidyan says.

The diabetes team educated the physicians, nurses, and the rest of the treatment team on the importance of glycemic control.

"We had to change the culture of the hospital. We did in-service training on every floor and every nursing shift and emphasized that we couldn't keep doing it the old way," Rofougaran says.

Protocols that address diabetes at the onset of treatment are embedded in SSM St. Mary's electronic health record. The protocol alerts the diabetes team if any patient admitted has high or low blood sugar levels.

When case managers review the medical record each morning, they look at patients with high and low blood sugars and determine what is going on with the patient.

"Diabetic teaching nurses review every single patient to determine what they need to keep their blood sugar under control and call the hospitalist or the attending physician when it is appropriate," Vaidyan says.

During the initial assessment, the case manager determines which patients are going to need diabetes education before discharge and alerts the diabetes educator.

"Our goal is to start getting the patients ready for discharge on day 1 so all we have to do is hand them the prescription for their medication when it's time for them to go home. Since we began this proactive approach, we have very few patients whose length of stay has increased because their diabetes issues have not been addressed," Rofougaran says.

In addition to treating patients while they are in the hospital, the diabetes team works to ensure that patients who don't have insurance, are without a medical home, and/or have poor health literacy receive the care they need as they transition from the hospital to the community, he adds.

"Our vision is to get the blood sugar under control while the patient is in the hospital and make sure that he or she has the necessary care after discharge to prevent readmissions, increase patient satisfaction, and enhance the patient's well-being," he adds.

Case managers are an important part of the treatment team because their assessment determines early in the stay which patients need help in accessing or getting their prescriptions filled after discharge, he says.

"Case managers have an important role in helping us prevent readmissions by assuring that patients with no resources and health care access have follow-up care in the community. If they don't have a primary care physician, the case managers call the referral coordinator to identify a community clinic and make sure that they can be seen within a week," he adds.

If patients don't have a physician in the community and can't get into a community clinic within a week after discharge, the case managers can refer them to Rofougaran's office for interim care. Rofougaran's office staff make follow-up calls to make sure patients understand their treatment plan.

Case managers and social workers are often called on to address low health literacy issues, noncompliance issues, and to help patients with no insurance.

"Case managers are an important part of the multidisciplinary team. They ensure that the patients will be able to keep their blood sugar under control after discharge by identifying community resources that can provide supplies and medication to patients who can't afford them. If a patient doesn't get his prescription filled after discharge, it doesn't matter what we do here, the diabetic is likely to develop complications and be rehospitalized," he adds. ■

CNE questions

13. In the final rule for the inpatient prospective payment system, CMS announced the market basket update that hospitals will receive in fiscal year 2011. What is the percentage of the update?
A. 2.35%
B. 2.9%
C. -2.9%
D. -0.4%

14. What are the hours that patient flow nurses at McKay-Dee hospital work?
A. 9 a.m. to 5 p.m. Monday through Friday
B. 9 a.m. to 5 p.m. seven days a week
C. 7 a.m. to 11 p.m. seven days a week
D. 24 hours a day, seven days a week

15. At Integris Baptist Medical Center, what's the most frequent way patients who would benefit from a palliative care consultation are identified?
A. Referrals from physicians
B. During multidisciplinary discharge planning rounds
C. At the request of the family
D. By the floor nurses

16. After SMS St. Mary's Health Center developed a glycemic control protocol, average blood glucose levels among patients in the ICU dropped from 180mg/dl to what level?
A. 140 mg/dl
B. 120 mg/dl
C. between 120 mg/dl and 130 mg/dl
D. between 140 mg/dl and 150 mg/dl

Answer key: 13. D; 14. D; 15. A; 16. C.

CNE instructions

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

Physicians use checklists for quality DP

Tool helps hospitals meet national quality measures

Mistakes happen even to the best clinicians. This is why hospitals increasingly are relying on checklists and other tools to assist clinicians in the discharge process.

One such tool, called a clinical decision support system, is an electronic checklist that enables hospital clinicians to meet all safety and quality goals every time they make a patient discharge.

The tool can assist hospitals with meeting quality measures used by the Hospital Quality Alliance (HQA) and Hospital Quality Incentive Demonstration (HQID) project.

A study comparing clinician compliance with heart disease treatment quality measures before and after use of an electronic checklist found significant improvement from the pre-intervention period to the post-intervention period. Clinicians' compliance with delivery of discharge instructions increased from 37.2% to 93% for acute myocardial infarction.[1]

Overall compliance with the cardiac discharge measures improved with the use of the clinical decision support system from 76.8% in the pre-intervention period to 96.8% in the post-intervention period.[1]

"It's not like a doctor ever wants to do the wrong thing, but you need another safety mechanism to assure 100% quality," says **Jeff Riggio**, MD, MS, physician advisor for information systems in the department of medicine, division of hospital medicine at Thomas Jefferson University Hospital in Philadelphia.

"We've realized the need to have systems in place, and having this as a computer-aided system has been helpful," Riggio says.

The hospital instituted the checklist for discharge planning involving cardiac patients with the help of a staff focus group and physician leaders, he says.

The movement toward using checklists partly is drawn from the airline industry, which instituted such processes to improve safety, he notes.

"The airline industry has translated many of its initiatives to improve quality and safety, and now we're taking advantage of their experiences," Riggio adds. "We're taking up their recommendations and adapting them for health care use."

Hospitals already have access to best practice guidelines. For instance, the Centers for Medicare & Medicaid Services (CMS) and the Hospital Quality Alliance have national quality initiatives. And various cardiac societies also have national guidelines involving cardiac care.

"So, we know what appropriate care is for our patients," Riggio says. "Unfortunately, to err is human, and people forget things; so we need a computerized system to help us achieve better compliance."

Electronic checklists can be useful tools for all clinical staff involved in the discharge process, including medical students, nurse practitioners, and attending physicians.

They works by having a section called the national quality measures section pop up on screen whenever a clinician keys in a specific diagnosis relevant to these measures.

"Once the appropriate diagnosis has been selected, there is a required checklist that needs to be performed before you can complete your documentation for the patient," Riggio explains. "You're forced to say whether or not you've prescribed an ACE inhibitor or given the patient appropriate discharge instructions."

The electronic system requires clinicians to answer a few questions before the discharge instructions are finalized.

"It takes an extra two minutes, if that long," Riggio says. "It's a mandated checklist. And for heart failure patients, there are two questions; and for acute myocardial infarction patients, there are four questions."

For a specific diagnosis, the electronic system will list patient instructions. These include having patients weigh themselves daily, follow their prescribed diet, know their activity recommendations, and understand their medication instructions.

"The program will require you to put in a follow-up post, and the program will have specific instructions for heart failure patients, talking about what to do if symptoms get worse and how to monitor weight," Riggio says. "This is automatically included in what's printed out for the patient."

Physicians can use their desktop computers to create the discharge instructions, which are all Web-based and available on the hospital's intranet, he adds.

"We're looking at putting computers in every room, but that's in the future," Riggio says.

One of the big mistakes that an electronic checklist can prevent involves whether or not phy-

sicians have reminded patients to take aspirin or prescribed an ACE inhibitor, he notes.

"For heart failure patients, the electronic prompt will remind them that the patient needs to be on an ACE inhibitor," Riggio says. "It reminds the discharging physician, because sometimes the discharging physician is not the physician who took care of the patient the entire time."

These continual hospital hand-offs are windows in which mistakes can occur, so the checklist is helpful in making sure the necessary communication occurs.

"It helps to double-check on prescriptions," Riggio says. "The physician might say that when the kidney function is better, we'll start an ACE inhibitor, and this will remind them to prescribe the drug."

The checklist also provides transparency in hospital care, and it's printed out and given to patients, who can see the quality measures for themselves. The total discharge instructions might be five pages with headers and page breaks; they're self-explanatory, listing medications and instructions about when to call a doctor. There are icons highlighting the various sections.

"Patients will be aware of quality standards for their disease process," Riggio says. "Patients often are never involved or see the end result; but we actually give them a copy of it, because this is one of the few documents we give patients routinely."

Some physicians and hospitals might debate the wisdom of sharing this information with patients, but from Riggio's perspective, it is the right move: "We felt this was the future [of medicine], to empower patients and have them understand these decisions we're making."

Typically, the physician will review the instructions with patients, although nurses might also be involved, Riggio says.

The other benefit to sharing the information is that the patient can take it to his or her community physician, who now will know why particular drugs were prescribed or not prescribed, he adds.

"Copies of these discharge instructions also could be sent to outside referring clinicians," he says.

The electronic checklist could be used by various health care systems as a means to improve clinical decision support at discharge.

"We've been working on rolling this out at an affiliate hospital in South Philly," Riggio says. "It has translatability to many different systems and hospitals."

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

- Using HCAHPS in your quality improvement initiatives
- Redesigning your case management department
- Tailoring a treatment plan to elderly patients
- How to prepare for RAC auditors

REFERENCE

1. Riggio JM, Sorokin R, Moxey ED, et al. Effectiveness of a clinical-decision-support system in improving compliance with cardiac-care quality measures and supporting resident training. *Acad Med*. 2009;84(12):1719-1726.

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