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Feds bringing out the big hammer to reduce rehospitalizations

Health care reform act will drive significant changes

The federal government has made clear many times in the past that if an industry can't clean up its own house, the feds will come in and do it for them — in a way far more onerous than anything the industry might have done on its own. That's what is about to happen with discharge planning, say some industry insiders.

The Patient Protection and Affordable Care Act (PPACA) contains provisions that will move the government a step closer to instituting penalties for rehospitalizations that will force providers to find a solution to this vexing problem, says **Vincent Mor**, PhD, professor of medical science in the Department of Community Health at Brown University Medical School in Providence, RI. Mor is the lead author of a commentary in the *Journal of the American Medical Association* addressing the coming changes in discharge planning.[1]

Discharge planning is now the focus of government regulators like never before, Mor says.

"There has always been discussion about discharge planning, but in terms of the daily operation of a hospital and what gets emphasis, what people have their hands spanked for, it's not been discharge planning problems," Mor says. "The hospitals essentially aren't penalized for falling down on the job or not doing a great handoff."

CMS has been moving toward penalties

Over the last decade, the Centers for Medicare & Medicaid Services has made minor revisions to hospital reimbursement rules designed to penalize hospitals for discharging patients prematurely to post-acute settings, Mor explains. However, the length of hospital stay has continued to decrease, and rehospitalization rates have increased, he says.

"It is no surprise, then, that the Affordable Care Act has multiple provisions designed to reduce rehospitalization," Mor and his colleague wrote in *JAMA*. "In the next year, the Centers for Medicare & Medicaid Services is charged with developing penalties for health care organizations whose patients are rehospitalized 'too often.' Whether hospitals or the post-acute care organizations will be penalized has not yet been specified, but this

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provision of the law has raised anxiety levels throughout the acute and post-acute care sectors."

PPACA requires that the government develop and implement a strategy for reducing rehospitalizations by Jan. 1, 2012. Mor tells *Discharge Planning Advisor* that although there is much uncertainty regarding what will happen in the near future, there is no doubt that providers will be forced to address discharge planning in a more effective way — not simply because it is the right thing to do for patients and can avoid rehospitalization costs for the provider, but because the government-imposed penalties will be unbearable.

"Changes are coming. It's just a matter of exactly what kind. There will be some form of penalty for someone for what they call excessive rehospitalizations," he says. "It's not clear yet who will take the hit, but it's likely going to be the hospitals."

ACOs seen as one solution

Mor explains that two strategies have been proposed to increase clinical accountability for transitions. One is the creation of accountable care organizations (ACOs), composed of consortia of hospitals, physician groups, and other health care organizations designed to serve populations of patients within a global budget. The other involves "bundling" Medicare acute and post-acute payments.

A big unanswered question is how hospitals, medical staffs, and post-acute referral sources will collaborate to share the payment bundle and reduce rehospitalizations, Mor says. Some options include nurse case managers or other "coaches" in the hospital or in the community following discharge, for instance, but how would those care managers be reimbursed? Would they be part of the hospital staff or the primary care physician staff?

"There are a number of demonstration projects now that are considering how bundling might be implemented, so there are scenarios that could be used nationwide," Mor says."These might be packaged in some form of pay-for-performance with a focus on rehospitalization, just like the current CMS demonstration in three states that focuses on nursing home care."

Hospitals have little incentive to collaborate and reduce hospitalizations unless there is a penalty for having the patient readmitted, Mor says, and the government seems to have realized that is a key part of the solution. Whatever form the penalty

takes, health care providers can count on rehospitalization becoming a bigger financial hazard than it already is for hospitals, Mor says.

"Large geographic variation in the supply of acute as well as post-acute settings means that solutions will by necessity have to be different," the authors write. "This level of flexibility is characteristic of how ACOs are being discussed, but to date there has been little mention of the roles post-acute and other community-based service organizations might play in ACO networks. It is time to begin such discussions to address the dilemma of patients and families being forced to make hurried and poor choices during the most stressful times of their lives."

Identify post-acute care partners

Clearly, there are exceptions to the rule, and some hospitals have created outstanding discharge programs that serve their communities well, Mor says. The federal incentives will force other hospitals to raise their game, he says.

So, how can hospitals improve their focus on discharge planning and be best prepared for the federal incentives? Mor suggests that hospitals begin to identify post-acute care providers — home health, long-term care, skilled nursing facilities, or others — with whom they want to establish protocols and close linkage. The goal should be not only to support the hospitals in preventing the patients from bouncing back, but also to ensure that the patients directed to those facilities are chosen properly and their needs can be met, Mor says.

"The post-acute care providers need to be your partners if you're going to make this work. You have to work together if you want to have a real impact on rehospitalizations," Mor says. "My colleagues in the world of long-term care say that hospital CEOs are answering their phone calls for the first time in a long while. That's a good indicator that people are waking up."

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SOURCE

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Enhanced discharge planning by phone yields results

RUMC tries telephone intervention

Telephone intervention can improve discharge planning when it is done in the right way, by the right people, according to the results of a program at Rush University Medical Center in Chicago.

Discharge planners know that simply having a nurse call after discharge to see if the patient is faring well will have limited effectiveness, but the program at Rush goes far beyond that, with specially trained social workers and an algorithm of risk factors and potential interventions.

The program, first implemented in 2007, succeeded in reducing readmissions within 30 days for seniors and mortality, although specific numbers are still being compiled.

The program targets seniors 65 years of age and older who are discharged to their homes and have multiple prescribed medications, plus other risk factors, notes **Robyn Golden**, LCSW, director of the older adult programs at Rush. Within 48 hours of discharge from the hospital, the patient receives a call from a Rush social worker, whose responsibility is to ensure full implementation of the discharge plan, assist with coordinating community resources and follow-up appointments, and intervene around any issues that might arise once the patient is back in the community. Those issues may range from transportation to meals and in-home care.

Over the three years of the Rush program, the social workers involved have found several common themes in post-discharge care, Golden says. Patients reported difficulty getting around after discharge, particularly if their illness affected their mobility. Patients also reported difficulty schedul-

EXECUTIVE SUMMARY

Rush University Medical Center is reporting good results with a discharge follow-up program in which high-risk patients are contacted by telephone. Social workers call with 48 hours of discharge.

- An algorithm of risks is used to identify patients for follow-up.
- A referral to home health services proved to be a high risk factor.
- Social workers are especially well suited to this type of follow-up.

ing medical appointments and getting to their physicians' offices, as well as delays in home health care services. Caregivers were often overwhelmed.

Most patients required attention

A study of the program found that issues requiring attention occurred in 83% of the cases, says **Madeleine Rooney**, MSW, LCSW, liaison, Older Adults Program at Rush University Medical Center. Rooney spearheaded the development of the enhanced discharge planning program.

For 74% of these individuals, the problems did not emerge until after hospital discharge, Rooney says. The study also found that those who received services, versus those who did not, were significantly more likely to follow up with their doctors after discharge, which is an important contributor to positive health outcomes.

The enhanced discharge planning program was developed in response to recent trends that complicate the continuation of care, Rooney says.

"Patients are leaving the hospital in shorter periods of time, and often, they are leaving with multiple chronic conditions or more complex care needs, especially for older adults," Rooney says. "We saw that we could meet an unmet need by making contact with patients identified as being at risk for complications or problems after discharge to do a follow-up assessment."

Social workers ideally suited

In other programs to help patients transition from hospital to home, nurses coordinate the after-hospital care, but Golden believes that social workers are ideally trained for the role.

According to Golden, research has shown that 40% to 50% of hospital readmissions are linked to social problems and lack of community services — issues that social workers are trained to address.

"Social workers possess extensive knowledge of community resources, expertise in navigating complex social systems, experience using a framework of practice that focuses on the person in the environment, and training in case management and care coordination," Golden says. "Social workers are also able to use psychosocial assessment skills to explore family dynamics or resources that may affect the success of the discharge plan."

The program initially was targeted at patients older than 65 in four units of the medical center, Rooney explains. Case managers on those units identified at-risk patients using subjective criteria. For instance, the case manager might have made a referral to the Department of Aging but wasn't sure what the status of the referral was, or the patient was referred to home health — but the case manager was worried about the home health provider's ability to follow through and wanted Rooney and her colleagues to ensure that care was provided promptly. Financial difficulties also could trigger a referral.

After two years, Rush studied the data on referrals and what the social workers determined when they made the initial contact to the patients after discharge. During the two-year pilot period, a total of 1,248 referrals and 4,350 phone calls were made, and social workers connected with more than 1,400 older adults and/or their caregivers. The findings also show that 67% of pilot participants were not receiving necessary community services, following through on discharge recommendations, or coping with care demands. Sixty-one percent of patients required more than one call to resolve their identified issues, and the average number of calls per person was 3.49.

Algorithm of risk created

Using that information and risk factors identified in the literature, Rush developed an algorithm of risk in 2009, when the program was expanded to all units at the medical center. The algorithm used fields already available to clinicians in the hospital's electronic medical record system, typically completed by nursing and case management.

The risk factors include items such as admitted within the previous six months, number of medications, high-risk medications, and specific diagnoses, such as congestive heart failure, chronic obstructive pulmonary disease, HIV, and diabetes. Depression, mental health issues, substance abuse, and family conflicts also were identified risk factors.

"Interestingly, our research showed us that going home with home health was itself a risk factor," Rooney says. "There were problems and gaps with the provision of services by home health providers. So, we added that to our risk factors and will soon be adding pain, as well."

At about the same time, Rooney and her colleagues developed a template of intervention that included the most common problems found with post-discharge patients — transportation difficulties and financial problems, for example — and potential interventions to address those problems.

"One of the things that makes this model differ-

ent is that it is a very bio-psychosocial approach to assessing discharge," Rooney says. "When we prepare to contact a patient, we're looking in our electronic medical record to see what was the clinical picture, what was the discharge plan of care, who were they supposed to follow up with, and so forth. But equally important to us was the many psychosocial and environmental issues that we know impact health outcomes, which often get minimized in the typical model. Discharge planning is usually practiced with a very medical model of care."

Team discusses discharge daily

Rooney notes that the enhanced discharge planning program meshes well with the federal government's drive to require a more effective and comprehensive care plan for patients, and the likelihood that reimbursement will be tied into rehospitalization rates. With that pressure in mind, the administration at Rush is studying the effectiveness of discharges at the hospital and piloting a program on one medical/surgical unit that involves a multidisciplinary team that meets every day at 10 a.m. to assess patients and plan for discharge.

The core team includes direct care nurses, case managers, hospitalists, clinical pharmacists, and an enhanced discharge planning social worker. Others join the team occasionally, Rooney says, including chaplains, dietitians, and physical therapists.

All of the patients on the unit are assessed using the discharge planning risk algorithm, and a report is generated for the team each day. Patients with one or more risk factors prompt the team to discuss potential interventions to improve the post-discharge plan, even from the patient's first day of admission. For instance, the team may identify that a patient will need to be educated about post-discharge medications, so that task is assigned, and then the team checks the next day to confirm that it was completed.

Rush also addressed the fact that a home health referral was a risk factor. Rooney and her colleagues met with many of the home health agencies in the community to discuss standards and quality of care, then created a set of expectations for the home health provider. For instance, a nurse must visit the patient within 48 hours, and any required physical therapy visit must occur within 72 hours. In a pilot with five agencies, Rush now requires the home health provider to file a regular report that tracks how well it has met those expectations — and to notify case management immediately if it identifies that an expectation cannot be met for a patient.

In its efforts to find new ways to help patients transition from hospital to home, Rush is also participating in Project BOOST (Better Outcomes for Older Adults through Safe Transition), a national project involving 30 hospitals to redesign the discharge process. Rush is the only hospital in Illinois included in the project. Like Rush's enhanced discharge planning program, Project BOOST, sponsored by the Society of Hospital Medicine, is aimed at reducing readmissions.

In December 2010, Rush received a two-year, $400,000 grant from the federal Administration on Aging and the Centers for Medicare & Medicaid Services to provide transitional care to older adults and people with disabilities. The grant will help extend Rush's enhanced discharge planning program to a new population.

(Editor's note: *Rush offers guidance to other hospitals interested in replicating the enhanced discharge planning program. For more information contact Rooney or her fellow social worker in the program, Gayle E. Shier, MSW.*)

SOURCES

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Special action team for first hours of discharge

A "high risk for readmission action team" (HRRAT) could be the way to address one of the weakest points in the discharge process, the day or two immediately after the patient goes home, says one doctor in Texas.

Arun Mathews, MD, a hospitalist at Medical Center Hospital in Odessa, TX, says his hospital has a readmission rate of about 5%, and he is proposing a regional HRRAT to bring that number down and save money.

The team would be led by an inpatient physician, preferably a hospitalist, along with an outpatient physician, who would identify patients with certain high-risk conditions, such as end-state chronic obstructive pulmonary disease (COPD)

EXECUTIVE SUMMARY

A Texas hospitalist is proposing a "high risk for readmission action team" to reduce readmissions. The team would address potential problems in the first 72 hours after discharge.

- The team would include a hospitalist and an outpatient physician.
- The hospital also uses a "discharge goal" determined at the time of admission.
- Progress toward the discharge goal is charted daily.

or congestive heart failure, Mathews says. The HRRAT also would flag patients who are sent home with "gap measures," such as home oxygen, which increases the chance of readmission.

"This team would be the tip of the spear with home visits," Mathews says. "We're really talking about the 48- to 72-hour window between discharge and the first post-discharge outpatient appointment. That's when the bulk of our readmissions come from. So, this team would visit in that window to reduce readmissions and identify patients who are not doing well."

If the team discovers problems that could lead to readmission, it can address them either through direct intervention or referral to outpatient care, Mathews explains. The HRRAT team is still being developed, but Mathews says he expects it to be employed at the hospital — and perhaps on a regional basis — soon.

Discharge goal determined at outset

Medical Center Hospital already is improving discharge by encouraging physicians to create a "discharge goal" at the beginning of care, Mathews says. He has been studying the effect of work flow and processes on patients' post-discharge outcome and says he has identified a number of best practices.

"All good things begin with the end in sight," Mathews says. With that in mind, Mathews and his colleagues create a discharge goal for the patient using specific clinical targets for the optimal discharge.

"At the moment of admission, based on even a cursory understanding of the primary diagnosis, comorbidities, and the patient's demographics, one can start to develop an estimate as to what the length of stay should be," Mathews says. "We actively encourage our hospitalists to document this as what we call a discharge goal, and then to mention this in the daily progress notes to show what progress has been made toward this discharge goal."

For example, in a patient with a community-acquired pneumonia who is admitted with hypoxia and sepsis, the discharge goal would be dependent on a period of 24 hours with defervescence from fever, white cell counts trending down, no systemic inflammatory response indicators, and hypoxia is clinically improving. Those factors would be charted on the daily progress notes, providing a check-off list that shows how quickly the patient is improving.

"We also see that translating into more accurate and appropriate billable codes," Mathews says.

The next part of the process involves the hospitalists discussing inpatient management best behaviors, acknowledging that there is a right time and a right test for different pathologies.

"We acknowledge that a little bit of knee pain with a patient coming in [with] community-acquired pneumonia doesn't necessarily warrant an MRI in the inpatient setting, that there is a role for outpatient workups," Mathews says. "We also address consultant management. The hospitalist needs to take a role of leadership, keeping everyone on the same page, ordering consultations effectively."

Cut readmissions to zero?

Mathews is working with **Ravi Shakamuri**, MS, chief executive officer of Star Health Care & Star Care Health Services in Odessa, TX, to coordinate the outpatient and home health services that would make such a system possible. Shakamuri says the HRRAT could fill a need for post-acute care patients.

"There are so many resources within the hospital walls, but once they pass out into the community, these resources tend to get diluted and lost in the day to day life of the patients," he says. "Their families and physicians are not connected, and that lack of care in the first day of two after discharge can result in hospitalization again, whereas a relatively small amount of attention in those hours might make the difference."

By using the discharge goal and the HRRAT, Mathews hopes to sharply reduce readmissions. The two-pronged approach should ensure that patients receive the proper care while hospitalized and are not discharged until it is appropriate, and then the HRRAT can intervene with any problems that occur in the first, most vulnerable hours after discharge.

"I genuinely believe that hospital readmissions can be brought down to virtually zero with

the implementation of such a process," he says. "That's a bold statement, but I think it can be done."

SOURCES

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ACOs emphasize prevention, coordination

Partnerships aim to improve care, eliminate waste

As talk of reimbursement reform and pay-for-performance escalates and health care stakeholders look at ways to improve patient access and outcomes while reducing waste and costs, payers and providers are joining together to create accountable care organizations (ACOs), partnerships that agree to be accountable for the quality, costs, and overall care of a patient population.

Accountable care organizations are patient-centered partnerships between payers and providers and have an emphasis on prevention and care management across the continuum.

In an accountable care organization, the payer, the providers, and, in some cases, the purchaser agree on a payment model and share the savings as waste is eliminated.

According to **Richard Bankowitz**, MD, MBA, SACP, enterprise-wide chief medical officer for Premier, an alliance of health care providers with a mission to improve the health of the communities, the ACO initiative has a triple mission:

- to improve population health;
- to improve the care experience;
- to reduce the total cost of care.

"To be part of an accountable care organization is any case manager's dream. Accountable care brings to the forefront what case managers have been talking about for decades: the need to have solidly constructed and effective multidisciplinary teams. As case managers, we know how important it is for the patient experience across the continuum of care to be seamless; but it remains a bumpy ride. ACOs are designed to eliminate the bumps and gaps in care," says **Victoria Choate**, RN, CCM, RN-BC, CCP, PAHM, vice president of performance excellence and chief quality officer at Cheyenne Regional Medical Center in Cheyenne, WY.

Cheyenne Regional Medical Center is partnering with a local health plan and a physician organization to develop and implement an ACO.

The accountable care model places the focus in health care back where it belongs — on improving the health of individuals, says **David Epstein**, MD, CIGNA senior medical director for Georgia. The Philadelphia-based health service company and Piedmont Physicians Group, part of Atlanta-based Piedmont Health, have launched an ACO pilot program.

"Health care in the United States has shifted away from prevention and primary care, which has resulted in a 'disease care' system that relies more on specialist intervention and rescue procedures rather than improving health and providing greater value to patients. The patient-centered model places the emphasis on improving the health of individuals through comprehensive primary care services and delivering better outcomes through enhanced care coordination," Epstein says.

The goal of the accountable care organization initiative is to improve quality and moderate costs, Choate says.

"We don't want to eliminate necessary costs, but by anticipating what the patients' care needs are and by shepherding them across the care continuum, we want to eliminate the costs associated with unnecessary care," she says.

Studies have shown that up to 30% of health care funds are spent on unnecessary and duplicative tests, treating complications that could have been avoided, and providing care in an expensive setting when it could have been provided at a lower level of care, Bankowitz says.

"The current system simply is not sustainable. The accountable care model is an exciting concept and one that is badly needed," he says.

The primary problem with the current health care system is that care is fragmented and not coordinated from the patient's point of view, Choate says.

"Patients often see several providers in multiple settings. Sometimes their records are available, and sometimes not. There is a lot of duplication of services and waste. Accountable care organizations provide a mechanism to coordinate care and eliminate duplication across the continuum," she says.

Fragmented care can lead to medical errors and waste, Bankowitz says.

Accountable care organizations are designed to eliminate waste and unnecessary spending and to ensure that patients get preventive care that will keep them well by proactively managing chronic disease and coordinating care provided in multiple settings, Bankowitz says.

"Everybody tries to eliminate waste, but one of the realities of the current model is that if you eliminate waste and reduce unnecessary emergency department and hospital visits, the savings go to the payer, and hopefully back to the purchaser and the consumer. There is no incentive on the part of the provider to eliminate waste," he says.

Accountable care organizations require an infrastructure that includes a person-centered health home provider, a mechanism for coordinating care, and a way to share information.

"We need health care professionals who are trained to think about the whole continuum of care, how to coordinate care, and how to be proactive to help patients get the level of care they need but not receive wasteful or unnecessary care," Bankowitz says.

The model may differ depending on the needs of the communities and the structure of the collaborating organizations, but all include payer/provider partnerships and reimbursement models that reward providers for providing value rather than on the basis of patient volume, Bankowitz says.

Payers always have been especially interested in cost and quality, he says.

"Their role is to provide for efficient care of the patient, and that hasn't changed. What is changing is that we are looking at the whole delivery model and not just the payment model. The delivery model is changing with better coordination of care and emphasis on the patient's health home," he says.

Premier is partnering with nearly 80 health care systems nationwide to help them develop and implement the accountable care model in their areas.

The ACO Implementation Collaborative is designed to assist health systems in partnering with payers and physician practices to implement the model in their area. Twenty-four health systems with more than 80 hospitals are participating in the collaborative.

More than 50 health care systems are part of Premier's ACO readiness collaborative and are developing the organization, skills, team, and operational capacities needed to develop the model in their areas.

"We brought hospitals to the table, because the organization's owners are hospitals; but it can't be solely a hospital activity. Patients receive care along the continuum within multiple levels. If care isn't coordinated, it results in excess services and waste and has the potential for errors," he says.

Regardless of the structure of the model, accountable care organizations all include people-centered health homes that deliver primary care and coordinate with other providers as patients move through the health care continuum, Bankowitz says.

"Historically, continuity of care has been a series of hand-offs. Now, people are sitting at the table and discussing what the patient needs in their environment and what is needed when the patient goes to another level of care," Choate says.

The initiative refers to "person-focused care" rather than "patient-focused" care and "health homes" rather than "medical homes," because an accountable care organization looks at the health of a population and keeping a population healthy.

"Many individuals in that population may be healthy, and they're not patients. We want to keep them as healthy as possible. That is why this model has greater emphasis on primary care and preventive care," he says.

Under the accountable care model, the case managers' role will continue to be to promote better coordination of care, elimination of waste, and duplicated efforts, Bankowitz says.

"The scope of work for case managers may change, because now case managers tend to focus on a patient or a case, whereas in the new accountable care organization, their job may be more of health management. We are not interested only in taking care of sick people; we want to keep people healthy and out of the system if they don't need to be there," he says.

The principles and goals of accountable care organizations are similar to those envisioned in the capitated payment programs in the 1990s, Epstein says.

"The premise of the capitation program was to empower the primary care physicians to improve their patients' overall health and to guide them effectively through the health care system when necessary, as opposed to simply referring them to various hospitals and specialists when they need specialty care. Some primary care groups were prepared to take on population health management tasks and did quite well under the capitated system. But the program did not succeed in moving

the quality dial due to lack of infrastructure and constructive dialogue between the provider community and the payers. Accountable care organizations have the potential to deliver more efficient care and better health outcomes through enhanced care coordination," he says. ■

Insurer, physicians team up for patient care

Goal of ACO pilot to increase quality, cut costs

When CIGNA members being treated by Piedmont Physicians Group in Atlanta are high-risk or noncompliant, **Jennifer Farlow**, RN, BSN, clinical care coordinator, contacts them and helps them get back on track for regular visits and recommended tests and procedures.

The health plan and the physician group split the cost of Farlow's salary as part of the two organization's accountable care organization pilot project.

The program, which began July 1, 2010, focuses on 10,000 individuals covered by CIGNA who receive care from one of more than 100 primary care physicians who are members of the Piedmont Physicians Group.

"Our goals are to increase quality and decrease the cost of care at the same time. We believe that we can achieve better clinical outcomes by collaborating to ensure that patients are receiving recommended care in a timely manner," says **David Epstein**, MD, CIGNA senior medical director for Georgia.

Epstein and other CIGNA officials meet every other week with the physician practice operational group and every other week with the clinical team to discuss how the project is going and brainstorm on any changes that need to be made.

CIGNA is providing data from its own case management and disease management program to the Piedmont organization.

"We are sitting at the table with providers, and for the first time in my career, I feel that instead of duplicating resources, we are sharing information and optimizing resources," Epstein says.

Farlow enhances patient care by coordinating CIGNA data and clinical programs of the Piedmont Physicians Group, Epstein says.

Each month, the health plan sends two reports to Farlow. A gap report shows patients who are missing recommended care, such as a diabetic who hasn't had a hemoglobin A1c test recently or a patient with heart failure who hasn't filled his prescription for a beta-blocker.

The other report, called the previse risk report, shows who is at highest risk in the patient population, such as patients who use the emergency department for certain diagnosis codes.

When CIGNA's claims information indicates that a patient has a gap in care, Farlow reviews the chart in the electronic medical record to make sure that the patient hasn't already seen the doctor.

"Sometimes there is a lag in the claims data, and when I look at our records, I find that the patient saw the doctor last week," she says.

When she identifies patients who have gaps in care, Farlow makes an outreach call and works to get them back in to see the doctor.

"When a doctor tells a patient to follow up in six months, he or she has to trust the patient to follow up. This program gives us a chance to make sure that they do follow through," she says.

Farlow contacts all patients who show up on the gap report, regardless of their disease state or medical conditions.

"Many patients have multiple comorbidities. When I call the patients, I find out how educated they are about their conditions and identify their goals. I reinforce the education they have gotten and work with them to follow their treatment plan," she says. For instance, she says she finds that many diabetics check their blood sugar only once a week.

"I try to establish a rapport with every person I contact. If I know they have a lot going on or are having trouble being compliant, I make follow-up phone calls and support their adherence with the treatment plan," she says.

After she talks to the patients, Farlow sends a follow-up letter to them and sends the information to the physician by entering it into the computerized charting system.

She helps patients who have issues getting their prescriptions refilled or have a question about medication.

The program also targets patients who are making multiple visits to the emergency department for simple things that should be treated in another venue. When Farlow talks with them, she identifies the barriers to care.

For instance, some patients have told Farlow that they use the emergency department frequently

because they can't afford the copay for a primary care visit.

In those cases, she works with the physician practice manager to set up a payment plan so the patient can get treatment at the appropriate level of care.

"Access to care is a big issue. Some patients try to see the doctor, and they can't get an appointment so they end up going to the emergency department for treatment. One of our major focuses in improving access to care is making sure there are same-day appointments available for patients who need to be seen," she says.

The physician group is working on ways to increase the number of same-day appointments available by expanding office hours, providing weekend care, and, in some cases, triaging after-hours callers rather than having a recording that tells them to hang up and go to the emergency department, Epstein says.

The primary goal of the care coordinator is to get patients with gaps in care, or who are using the emergency department inappropriately back into the physician office, Epstein says.

"In a way, she's playing family therapist, trying to get the two parties back together. That is the epicenter of how this process works. The patient needs to see his or her physician on a regular basis and receive recommended care. At the same time, the physicians need to make sure patients have access to care. If someone has a sore throat, they can't wait three weeks for an appointment," he says.

The outreach calls are particularly effective, because they are coming from the patient's doctor and not from CIGNA, Epstein points out.

"It's not the message as much as it is the messenger. The subject of the call and the information passed on could be exactly the same, but because it's coming from within the physician practice, and not from the insurer, the patient is more likely to pay attention. The physician practice has a lot more credibility than the insurer," he says.

The initiative also is addressing hospital readmissions in real-time, Epstein points out.

"When patients leave the hospital, there's often not enough good communication with the primary care physician. This program bridges that gap and makes sure patients receive a follow-up visit, that they get their medication, and understand their treatment plan," Epstein says.

Farlow collaborated with the case managers at Piedmont Hospital and is able to access their documentation system for information on the patients she is following.

"I can see who is in the hospital, who is in the emergency department, when they are discharged, and follow up to make sure they receive appropriate outpatient care. Our hope is to get them back to see their primary care physician or a relevant specialist and avoid any rehospitalization," she says.

She typically coordinates care for patients over the telephone. The physician group has 40 offices throughout the metropolitan Atlanta area, which makes it impossible for her to see everyone in person.

Farlow has a weekly conference call with the lead CIGNA case manager assigned to the Piedmont account, the health plan's health service specialists, and Epstein.

The health service specialist is the individual who understands the benefit plan eligibility and what each employee has purchased.

That way if the care coordinator is working with a patient with diabetes who doesn't know his or her benefits, the health service specialist can let that coordinator know what the health plan can offer the patient.

"We cover the administrative bases as well as the clinical bases," Epstein says.

The project is a collaboration between CIGNA and Atlanta-based Piedmont Physicians Group and is the first accountable care organization in Georgia. The project is one of several accountable care organizations the Philadelphia-based health service company is developing nationwide.

"We have a relationship with the Piedmont system on two levels. They are a key provider system in our network, and we administer their health benefits plan," Epstein says.

CIGNA is paying the primary care physicians as usual for the medical services they provide in addition to a fee for care coordination and other medical home services. The physicians also will be rewarded through a pay-for-performance structure if they meet targets for improving quality and lowering medical costs.

"We are going to analyze data from the project using evidence-based measures and compare it to baseline quality performance. We're also looking at the effects on costs year over year and trends in cost reduction. We believe this project will result in better clinical outcomes and save money at the same time," Epstein says. ■

Use hand cleansers to decrease absenteeism

Get workers thinking about it

Use of alcohol-based hand cleansers significantly reduced several common infections and reduced absenteeism in a study of 129 white-collar workers in 2005 to 2006, according to research from the Institute of Hygiene and Environmental Medicine in Greifswald, Germany.[1]

Participants were told to wet their hands fully with the rubs at least five times a day, especially after visiting the restroom, blowing their noses, before eating, and after touching other people or papers. No hand-hygiene behaviors were suggested to the control group.

Putting disinfectants on employees' desks helped reduce absenteeism as well, with workdays lost because of diarrhea cut dramatically.

"Hand cleansers are an important component of an overall approach to creating a culture of health at a business location," says **Brent Pawlecki**, MD, corporate medical director at Stamford, CT-based Pitney Bowes. "Hand hygiene is something that we want our employees thinking about at all times."

Because the hand sanitizing stations are so noticeable, their strategic placement can set a tone for the workplace. "This has symbolic value, by encouraging hand hygiene even when the employees are not passing by the station itself," says Pawlecki.

At Pitney Bowes' headquarters, the first sanitizing station that visitors and employees who use the main entrance see is right in the lobby. In addition, sanitizers were installed in high-traffic locations: the entrances to the main cafeteria, fitness center, and the on-site clinic.

Every single restroom in the company's facilities has signage with tips on how to wash hands effectively, and instructions on how to leave the restroom in a hand-healthy manner. That means drying your hands with a clean paper towel, and using that same towel to turn off the water at the sink and open the door when leaving.

"We provide a wastebasket next to the outer door of every restroom for convenient disposal of used paper towels," says Pawlecki.

Pawlecki says that he believes that accessibility of hand cleansers does have an impact on absenteeism.

"It certainly helps, although we have not undertaken a comprehensive study to prove the degree to which it helps," he says. "There are many factors that influence absenteeism, but having a comprehensive and aggressive healthy-hands program can be a meaningful contributor to overall employee health, well-being, and productivity."

REFERENCE

1. Hubner, NO, Hubner C, Wodny M, et al. Effectiveness of alcohol-based hand disinfectants in a public administration: Impact on health and work performance related to acute respiratory symptoms and diarrhea. *BMC Infect Dis* 2010; 10:250; doi:10.1186/1471-2334-10-250. ■

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 May/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.

CNE objectives

Upon completion of this educational activity, participants should be able to:

- Identify particular clinical issues affecting discharge planning.
- Apply discharge planning regulations to the process of discharge planning.
- Describe how the discharge planning process affects patients and all providers along the continuum of care.
- Cite practical solutions associated with the discharge planning process based on independent recommendations from clinicians working in the field or from specific regulatory bodies.

CNE questions

1. The Patient Protection and Affordable Care Act (PPACA) contains provisions that will move the government a step closer to instituting penalties for rehospitalizations, forcing hospitals to develop solutions, according to Vincent Mor, PhD, professor of medical science in the Department of Community Health at Brown University Medical School.

A. True
B. False

2. Rush University Medical Center is reporting good results with a discharge follow-up program, whereby high-risk patients are called within what time frame post-discharge?

A. 12 hours
B. 24 hours
C. 48 hours
D. None of the above

3. According to Arun Mathews, MD, a hospitalist at Medical Center Hospital in Odessa, TX, a special "high risk for readmission action team" could be the way to address one of the weakest points in the discharge process, i.e., the day or two after the patient goes home.

A. True
B. False

4. According to Golden, research has shown that 40-50% of all readmissions are associated with lack of resources in the community as well as social problems.

A. True
B. False

Answers: 1. A; 2. C; 3. A.; 4. A

COMING IN FUTURE MONTHS

- WellStar became the only health system in metro Atlanta to have its own discharge call center in November 2010
- Improving relations with home health providers

Dear *Discharge Planning Advisor* Subscriber:

This issue of your newsletter marks the start of a new continuing nursing education (CNE) semester and provides us with an opportunity to review the procedures.

Discharge Planning Advisor, sponsored by AHC Media, provides you with evidence-based information and best practices that help you make informed decisions concerning treatment options and physician office practices. Our intent is the same as yours – the best possible patient care.

Upon completion of this educational activity, participants should be able to:
• **identify** particular clinical issues affecting discharge planning;
• **apply** discharge planning regulations to the process of discharge planning;
• **describe** how the discharge planning process affects patients and all providers along the continuum of care; and
• **cite** practical solutions associated with the discharge planning process based on independent recommendations from clinicicans working in the field or from specific regulatory bodies.

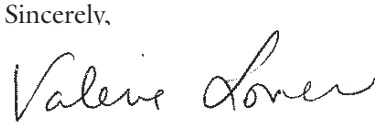
Each issue of your newsletter contains questions relating to the information provided in that issue. After reading the issue, answer the questions at the end of the issue to the best of your ability. You can then compare your answers against the correct answers provided in an answer key in the newsletter. If any of your answers were incorrect, please refer back to the source material to clarify any misunderstanding.

At the end of each semester you will receive an evaluation form to complete and return in an envelope we will provide. Please make sure you sign the attestation verifying that you have completed the activity as designed. Once we have received your completed evaluation form, we will mail you a letter of credit. This activity is valid 36 months from the date of publication. The target audience for this activity is hospital-based discharge planning advisors.

If you have any questions about the process, please call us at (800) 688-2421, or outside the U.S. at (404) 262-5476. You can also fax us at (800) 284-3291, or outside the U.S. at (404) 262-5560. You can also email us at: customerservice@ahcmedia.com.

On behalf of AHC Media, we thank you for your trust and look forward to a continuing education partnership.

Sincerely,



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