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HHS releases proposed ACO rules, highlighting care coordination

Rules would add to financial, paperwork burden

Proposed rules for the creation of accountable care organizations (ACOs) will require participating organizations to provide primary care to 5,000 or more patients and to meet 65 quality standards. Since the new ACOs also will require substantial start-up costs, some experts say it will be both a challenge and an opportunity for hospitals.

"ACOs is a concept that would allow our hospitals to participate and get recognized for many things they're already doing well, including coordinating care for purposes of reducing readmissions and eliminating certain hospital-acquired conditions," says **Lisa Graberg**, MPH, senior associate director for policy at the American Hospital Association in Washington, DC.

The Centers for Medicare & Medicaid Services (CMS) recently released its proposed rules for creating accountable care organizations with a focus on extent of care coordination and treatment of Medicare beneficiaries who are sick and frail. *(See story with ACO rule details, page 27.)*

"These are things a lot of our members are already doing, and there's a financial incentive for doing these sorts of things," Graberg adds. "Under ACOs, when you drive down costs you generate additional savings overall for the Medicare program, and then you're eligible to share in that savings with CMS."

Hospitals are better positioned than most providers to form ACOs because many already have several components of continuous care coordination in their systems, she notes.

"Also, hospitals and health systems tend to have greater access to capital, and to become an ACO will require a significant investment that CMS estimates at $1.8 million for start-up and first year of ongoing costs," Graberg says. "We've done some internal analysis and hired a contractor, and we think it's actually much more than $1.8 million."

Large physician groups also seem interested in the ACO model, says **Beverly Cunningham**, MS, RN, vice president of clinical performance improvement at Medical City Dallas Hospital.

"CMS did an open-door call in April, and the people who called in and asked the most questions were mostly large physician groups," she says. "I

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think hospitals will take this slowly."

Many hospitals now are focused on understanding their own readmissions, particularly in the big three of pneumonia, acute myocardial infarction, and heart failure. They also are putting processes in place that will help reduce them, Cunningham adds.

"While hospitals wait to see what happens with the rollout of health care reform, they'll have these processes in place," she says.

ACOs likely will improve the overall coordination of care, reduce duplication, and enhance prevention efforts, says **Donna Zazworsky**, RN, MS, CCM, FAAN, vice president for community health and continuum care at Carondelet Health Network in Tucson, AZ.

"This includes working with primary care providers," Zazworsky says. "We have those pieces in place for diabetes coordination of care, and we're already showing cost savings in being able to coordinate care better in the primary care."

The point of forming an ACO is to provide care in different ways that might improve both health care access and efficiency. An example might be Carondelet Health Network's 24-hour, seven-days-a-week telecardiology program that serves rural hospitals, she notes. *(See story on Carondelet's programs to improve care transitions and coordination, page 28.)*

Hospitals also are working more proactively in forging relationships with the next-level-of-care providers, the experts say.

"We're working with home health agencies and skilled nursing facilities to design agreements that help clearly define the transition process," Zazworsky says. "With home health agencies, we expect our patients to be seen within 24-48 hours post-discharge."

This immediate home health visit sometimes is necessary for step-down care, and it also ensures the discharge plan is being followed. Hospitals no longer can assume patients will follow through on discharge plans once they return home, she adds.

"Our experience now tells us they don't," Zazworsky says. "It's not because they don't want to, but they might not have the support system to get their medications for several days, which ends up with them returning to the hospital."

When home health care and other providers are not part of the major payer groups that serve the hospital's patients, the hospital will encourage payers to contract with the providers, Cunningham says.

"We encourage payers by saying, 'This is a company that is good; we have seen as we track them that they don't have a lot of readmissions and are really focused on managing the patient outside of

EXECUTIVE SUMMARY

- CMS releases proposed rule for ACOs, placing emphasis on coordination of care.
- ACOs will require a substantial start-up investment.
- ACOs likely will improve the overall coordination of care, reduce duplication, and enhance prevention.

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EDITORIAL QUESTIONS

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the hospital,'" Cunningham says. "Then we tell the providers, 'So why don't you work together and get a contract so you can take our patients?'"

These kind of efforts might accomplish some of the same benefits and reductions in readmissions that ACOs are designed to do. Some hospitals might choose to continue their own efforts before committing to an ACO, she says.

"We're not jumping into an ACO endeavor, but we're aggressively looking at readmissions and that next-level-of-care provider," Cunningham explains. "We feel if they go to that provider, they won't bounce back to the hospital."

Medical City Dallas Hospital also uses mid-level practitioners to manage high-risk patient populations. These include a heart failure nurse practitioner who identifies high-risk patients who are at risk for readmission, she says.

"We have wellness clinics for them," she says. "We identify the people who will be the most difficult to manage, and we assure their transition is appropriate and at the right level of care."

This has been going on for a few years, but the health care reform bill has encouraged the hospital to improve and to become better organized, she adds.

"Health care reform has forced us to be better than we are," she says.

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ACO rules could create a variety of new burdens

Expert offers suggestions for changes

The U.S. Department of Health and Human Services' recently published proposed rule (42 CFR 425) for Accountable Care Organizations (ACOs) could result in some positive changes for the health care industry, but there are a few problems that should be corrected, an expert says.

The proposed rules for the Centers for Medicare & Medicaid Services' (CMS) ACOs greatly expand quality domains and measures to be reported to CMS, and this likely will be onerous for hospitals, says **Lisa Graberg**, MPH, senior associate director for policy at the American Hospital Association in Washington, DC.

One issue is that the proposed rule will have ACOs meet 65 quality standards in these five areas:

- patients' care experience;
- extent of care continuum;
- patient safety;
- emphasis on preventive health;
- success in treating Medicare beneficiaries who are sick and frail.

"CMS did a physician group practice demonstration project that is a precursor to ACOs, and these sites are required to report on only 32 measures," she says. "To more than double the measures is concerning to us because our members are already reporting 60 measures for hospitals, and they'll have to report on 65 more without a whole lot of overlap."

Of course, hospitals do not have to establish ACOs, but starting an ACO will require extensive funding and infrastructure, so hospital systems are the best positioned to take on this task, Graberg says.

The proposed rule includes a downside risk without providing front-end funding. CMS estimates the ACO start-up costs would be nearly $2 million, Graberg notes.

The ACO program is based on the fee-for-service payments and system but provides incentives to cut costs through shared cost savings. ACOs that do well will receive an incentive payment reflecting part of that savings. They also can be penalized financially for exceeding their spending targets.

"When exposed to downside risk in the private sector, you typically receive some upside capital in a capitated budget, and then you stay within that budget," she explains. "But they're not getting any upside capital at all in this program, and the ACOs make the full investment themselves."

CMS could change this imbalance in the final rule.

"We'd rather see CMS come out with a partial capitation option that holds them accountable for risk, and also gives them some capital," Graberg says.

Also, CMS could have done more to emphasize

care coordination by providing upfront capital, she adds.

"Even if you do qualify for a savings bonus, it's likely you won't see any money for maybe 20 full months after you start the program," Graberg says.

That's a long time to receive money that could be used to improve care coordination, she adds.

"I do think for the most part our hospitals are already doing things like tackling readmissions, reducing infections, and so forth, but they're paying for all of those themselves," she says.

The ACOs shift incentives slightly in the direction of capitated care, but hospitals still will operate in a fee-for-service environment in which they are paid when patients are admitted and reducing readmissions actually reduces revenue, Graberg says.

"So when you don't receive additional upfront capital for the savings you are generating for the program, it becomes a tricky financial dance to continue," she explains. "The more successful you become, the less revenue you receive."

Hospitals increasingly are bridging the care transition process, and the creation of ACOs drives home the importance of this trend continuing, Graberg says.

"Whether or not a hospital elects to do an ACO, our members are fully on board and understand that we are responsible and give accountable care to all patients who come into the hospital," she adds. ■

How can you prepare for an ACO world?

Various strategies outlined

Some hospitals have been focusing more on care transition issues in anticipation of the advent of accountable care organizations (ACOs) or just because it's a way to improve both quality and efficiency in health care.

One health network in Arizona has implemented several projects and programs that lead to health care transition improvements, especially among high-risk populations.

"We use navigators who are community outreach workers to enroll people in a diabetes disease management program and to create a registry," says **Donna Zazworsky**, RN, MS, CCM, FAAN, vice president for community health and continuum care at Carondelet Health Network, a four-hospital system in Tucson, AZ.

"We identify the highest risk patients, and navigators get them into services," she explains. "They make sure they have their annual exams and have access to dietitians and educators in the doctor's office."

Navigators, who are nonclinical and must be supported by a nurse or other member of the clinical staff, also call patients who miss appointments and schedule and coordinate patients' contact with the care team. They help manage patient data, act as peer contacts who bridge language and cultural barriers, and assist patient interaction with the diabetes care team.

"It's all part of our patient-centered health care effort," Zazworsky says.

Here are some other areas in which the health network is focusing more on care transitions:

• **Pay close attention to heart failure patients.** "Heart failure is one of those major areas that hospitals need to target because there won't be payment for readmissions if people are readmitted within 30 days," Zazworsky says.

"You will see a lot of transitional programs where nurses, with the help of cardiologists and health managers, identify patients they pick up from inpatient care and follow them to the home," she explains. "They make sure they make their physician appointments, get their medications reconciled and filled, and provide some home visits and phone call follow-up."

Some transitional care nurses will even meet a patient in the doctor's office. This follow-up continues for 60 days and provides needed support to patients who are asked to do considerable daily monitoring, including checking their weight, symptoms, and taking a complicated medication regimen.

"Patients often have difficulty with that," Zazworsky says. "They're high risk, vulnerable, and may not have a family support system."

Transitional care nurses attend the patient's meetings with other providers and help patients understand their care instructions, she adds.

• **Hold other providers accountable.** When the hospital discharges a patient to his or her home and refers the case to a home health agency, the hospital has an expectation that the home health agency will do what it can to prevent readmission.

"We expect our patients to be seen within 24 to 48 hours post-discharge," Zazworsky says. "We expect a feedback loop."

The days of working in a silo where the patient

no longer is the hospital's patient upon discharge are ending, she notes.

ACOs will give hospitals and other providers economic incentives to be accountable for their patients throughout the entire care continuum, she says.

This means that hospitals will pay more attention to the home health agencies, nursing facilities, and other providers to whom they refer patients. And they'll develop preferred provider lists based on the community providers' quality and readmission data, Zazworsky suggests.

"We say to providers, 'If you want to be on our preferred provider list then these are our expectations,'" she adds.

• **Develop post-hospitalization clinics.** The key is to have patients visit their providers in a timely fashion after discharge.

"We work with a federally qualified health center that has a wonderful program for transitional care," Zazworsky says. "We make sure they are seen by a provider and have a discharge planning nurse."

The discharge nurse works with the newly discharged patient to make certain the community doctor visits take place, medication prescriptions are filled, and care instructions are followed.

Post-discharge clinics might have physicians, nurse practitioners, and/or physician assistants who are available to see any patient who is discharged from the hospital and who has a problem with getting in to see a primary care doctor for timely follow-up, Zazworsky says.

"With some physician practices, patients might wait two weeks to get in to see the doctor, and they could end up in the hospital again," she explains. "So the post-discharge clinic provides the initial visit, does medication reconciliation, and assesses whether the patient's self-management and care coordination are adequate."

• **Expanding access through telemedicine.** Carondelet Health Network has a telecardiology program that expands the reach of rural hospitals.

"A patient might come into a rural critical access hospital with congestive heart failure, unstable atrial fibrillation, or soft chest pain," Zazworsky says.

The rural hospital's emergency department physician can examine the patient and then initiate a telecardiology visit with a cardiologist at the urban hospital. The cardiologist helps the local physician decide whether to keep the patient at the rural hospital or ship to the urban center, she explains.

"You're delivering lower-cost care in a critical access hospital rather than paying for helicopter flights and hospitalization in an urban setting," she adds.

The health system's telemedicine program also includes teleneurology, telestroke, and tele-education in which professionals can be trained at any location, Zazworsky says.

SOURCE

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Follow-up program shows positive outcomes

Readmission rates lowered

Hospitals often have nurses call patients after discharge in hopes of improving their satisfaction ratings. A new study shows that there are a couple of very good reasons to provide these calls, but a boost in reported patient satisfaction is not one of them.

"A five-minute telephone call isn't going to change your perceptions about what happened while you were in the hospital," says **John David D'Amore**, MS, a researcher with the University of Texas School of Biomedical Informatics at Houston.

But here's what the five-minute nursing call did change:

• Readmission rates were lower for patients who received the telephone follow-up.

• Patient satisfaction survey return rates were higher for people who received the follow-up call.

The nursing calls originally were initiated years ago by Memorial Hermann Healthcare System of Houston as an informal process to check with patients post-discharge, says **Helen Powers**, BSN, MBA, assistant executive at Memorial Hermann Healthcare System, a multihospital system in Southeast Texas.

"Now that there are lots of financial incentives or penalties for readmission that are imposed by the federal government, then the follow-up calls are something that has to have an infrastructure," Powers says.

Memorial Hermann Healthcare uses an electronic post-discharge callback system for making and tracking the nursing calls.

"We wanted a system that would document and

make sure we made all the calls," says **John Murray**, MBA, senior business analyst with Memorial Hermann Healthcare System.

Clinicians in nursing departments make the calls, which include six standard questions, including questions about pain, discharge instructions, prescriptions, follow-up appointments with physicians, and an inquiry about recognizing any physicians or staff for a job well done.[1]

The last question has proved very useful for providing feedback to staff and departments, Murray notes.

"We're collecting 1,600 compliments per month through the system and 60 complaints, which are opportunities for improvement," he says. "We send emails to patient relations staff if there are concerns, and we pass on the compliments to department managers."

This particular question on the post-discharge callbacks was one that many hospital employees perceived would result in larger numbers of complaints, he says.

"Instead, we have 25 times as many compliments as complaints," Murray says.

The electronic system automatically lists patients who have been discharged home from each unit, and someone on that unit — usually a nurse or volunteer — makes the call, Powers says.

"This could be a layperson making the calls because it's pretty well scripted," she adds. "We try to ascertain the patient's level of comfort with their discharge information and identify any issues they need to address."

One key factor involves timing.

"We try to call the day after discharge or within that four-day window," Murray says. "We think our biggest opportunities are within those first four days after they go home."

From 2008 to 2009, 10 nursing units in the hospital, representing nearly 14,000 patient discharges, were examined. More than 10,500 received the post-discharge calls, and a little less than half were reached by the caller. Each nursing department spent about one to two hours per week conducting the follow-up calls.[1]

D'Amore and co-investigators conducted an observational study of data from an eight-month period to see what the outcomes were for the calls.

One outcome involved the patient satisfaction surveys, which were the Hospital Consumer Assessment of Healthcare Providers and Systems survey: "Patients always received the phone call before they received the survey in the mail, so did these calls influence patient satisfaction?" D'Amore says.

The answer was that the calls did not make any difference in survey results.

For the next outcome measure, investigators collapsed databases and connected data, including administrative data, readmission information, and demographic data that was de-identified, he says.

They examined the differences between patients who received the post-discharge callback and those who didn't and found that 22.4% of patients who received the calls mailed in the survey, versus 15% of patients who did not receive the calls.[1]

For 30-day readmission rates, the telephone follow-up combined with a scheduled physician appointment predicted a lower readmission rate. For those patients, the rate was 9.5% versus 10.8% for patients who did not receive the nursing call.[1]

The readmission results were positive enough to warrant a continuation of the callback system, Powers says.

"If you consider readmission after an acute episode is a failure in the system, then what you're doing is improving quality of care for patients by providing the calls," she says. "The readmissions could be caused by the patient not knowing what they were supposed to do post-discharge or because they're not taking their medications correctly."

The study's most illuminating finding was that the callbacks were most effective when combined with patients scheduling an appointment with their community physician, she notes.

"A number of the people we're readmitting to the hospital are not following up with their physician," Powers says.

The study's positive findings have long-term implications for hospitals, D'Amore says.

"This was a very encouraging study," he adds. "And Memorial Hermann has continued to expand the system and do more things to connect care."

For instance, if a patient does not have a scheduled follow-up visit with a physician, then the hospital post-discharge caller can transfer the patient to a scheduling system which would assist the patient in making that appointment, D'Amore says.

Also, the study's findings suggest there is a

EXECUTIVE SUMMARY

- Making follow-up calls to discharged patients can reduce readmissions.
- It also could result in increasing satisfaction survey returns.
- But don't expect a boost in positive satisfaction survey results.

positive relationship between having one hospital employee designated as responsible for making sure all discharged patients have appropriate follow-up care arrangements, Murray says.

"We can build relationships with primary care physicians in the hospital's area and channel more patients to physicians' practices by putting patients in touch with them," he explains. "We don't have data to analyze the impact of that, but our real goal is to make sure we can facilitate a primary care physician relationship before the patient leaves the hospital."

This type of continuity of care thinking and processes will lead the nation's health care system down the path of prospective management of care transitions and are much-needed, D'Amore says.

"It's creating a model where patients have to actively opt out," he adds. "The default position is they get appropriate care that is standard practice."

And it's good for hospital business: "We're not only doing this because it's the right thing to do, but CMS has identified this as a big cost driver in the health care arena and is issuing penalties in October 2012 for readmission rates above national average," Powers says.

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Care transition option involves house calls

Full services offered at home

Hospital readmission data often show that people who fail to see their primary care physician in a timely manner are more likely than other patients to return to the hospital within 30 days, a hospital performance improvement expert says.

Hospitals have addressed this problem through a variety of strategies, including nursing follow-up and phone calls, referring patients to transitional primary care clinics, and having a hospitalist or nurse call community providers to make appointments for patients. But there is one more new strategy that some hospitals are trying: referring patients to a physician house call service.

"The physician who goes to the house will see the patient within 30 days, serving as a bridge to the primary care physician," says **Beverly Cunningham**, MS, RN, vice president of clinical performance improvement at Medical City Dallas Hospital.

This is a physician-to-physician consult. A hospitalist will refer patients to the house call service based on the patient's case complexity, readmission risk, and the patient's preference.

The physicians making house calls can see the more complex patients who could stay at home with some extra medical support, Cunningham notes.

Physician house calls today are more technology-driven than 40 years ago. Physicians may visit the home with an assortment of clinic equipment, including lab and imaging machinery.

One company called American Physician Housecalls in Dallas can do in a patient's home most of the same diagnostic work a primary care clinic can do. This includes ultrasounds, echocardiogram studies, pulmonary function test, blood draws, and X-rays, says **Donald Graneto**, MD, director of transitional care for American Physician Housecalls.

There is a growing number of physician house call services marketed nationwide to older patients and others, but the latest trend is for these to have a hospital transitional care component.

"We started this model with different hospitals in our community," Graneto says. "What our transitional care service does is talk with hospital case managers to set up things for patients before they're discharged home."

Typically, hospitals will refer patients who might be unreliable in self-management of their chronic illness. An example is a diabetes patient

EXECUTIVE SUMMARY

• Physician house call transition program can bridge care gap for at-risk patients.
• Hospitalists refer patients to house call service based on patient's case complexity, readmission risk, and preference.
• Physicians visiting homes have access to some standard clinic technology, including imaging devices.

who sometimes forgets to take his insulin. This patient has an episode, is hospitalized, and then returns home with hospital discharge instructions. But then he continues to have difficulty remembering his medications and is re-hospitalized, Graneto explains.

A physician house call service can visit this patient soon after discharge to check his blood glucose levels and to reinforce the hospital's discharge and medication instructions. It might mean the physician refers the patient to a home care nurse for follow-up care and assistance.

Often the patients who do well with the house call service are people who may lack adequate family support due to the complexity of their cases or other reasons.

"These are complex patients going home, and they have the potential to bounce back," Cunningham says. "Their families could take care of them if they had a service available with physician house calls."

Medical City Dallas Hospital has been using American Physician Housecalls' hospital transitional care service for a few months. Now the hospital's emergency department (ED) physicians also are evaluating the program to see if it might help them with patients who make frequent ED visits, she adds.

It might also help with patients who go through the ED and then are admitted to the hospital because there are no suitable community options for their care.

An important part of hospital transitional care services and physician house calls is care coordination, Graneto says.

Physicians making house calls can evaluate the patient's caregiver support and review home health care services for the patient, he says.

Also, the house call physician provides a plan of care based on the hospital's discharge information. The goal is to prevent hospitalization and implement a plan that might include home health services, office visits to specialists, therapy, wound care, end-of-life discussions, and even community services like Meals on Wheels.

After the 30 days, the patient either will be transitioned back to his or her usual primary care provider or stay with the house call service, depending on his or her preference.

Medical City Dallas Hospital has no outcomes data yet on its use of the physician house call service, but anecdotal evidence suggests it's accomplishing the goal of reducing readmissions, Cunningham says.

"We haven't seen the patients come back, so it's like no news is good news," she says.

SOURCES

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LOS for heart failure drops with program

Program has 6 months follow-up

A nine-month study at a New York State hospital has shown that a well-planned transitional care program for heart failure patients can result in reduced readmissions, hospitalization costs, mortality rates, and length of stay.[1]

The intervention group of heart failure patients who were at high risk for rehospitalization had an average length of stay (LOS) of 5.1 days, compared with the comparison group's average LOS of 6.7 days, which suggests the intervention can result in a signifcantly lower LOS, notes **Cathleen Daley**, MS, RN, the heart failure coach at St. Peter's Cardiac & Vascular Center of St. Peters Hospital in Albany, NY.

Heart failure patients who received the transitional care intervention also had significantly lower costs, with an average cost per patient of $8,122 versus $10,175 for the comparison group. This represents a cost savings of $1,592 per individual hospitalization.

These promising results were due to a well-structured transitional care process that included assessing patients' health literacy as well as improving patient communication, education, and follow-up, she adds.

Here is how the transitional care program works:

• **Assess patient for readmission risk.** "It's difficult to determine which patients are at high risk for readmissions, so we spent three months defining the stratification criterion," Daley says.

They looked at every heart failure patient with this screening tool, and eventually determined that a patient who has even one of these risk factors is

more likely to be readmitted to the hospital:

- Was the patient admitted to the hospital two or more times in the past year?
- Did the patient have any two items within a set of Adhere Cart Criteria?
- Did the patient have a heart failure readmission within 30 days?
- Was the patient's ejection fraction less than or equal to 30%?
- Were there two of the three following comorbidities — renal failure, chronic obstructive pulmonary disease (COPD), or anemia?
- Was the patient newly diagnosed with heart failure?

"The patient might have met one or multiple of these criteria, but they only needed to meet one to qualify for the program," Daley says.

• **Screen patient for health literacy.** "Once they qualify for the program, they are interviewed by me at the bedside with their family," Daley says. "I screen them for health literacy."

Daley tells the patient that she has a laminated food label they could pretend is for ice cream. She explains that she will ask them about this label because it will help her with the education she'll be doing with them.

"Then I ask them specific questions about the label," she says.

The label is 8.5 by 11 inches and has large type to make it easier for elderly patients to see. Since some patients will be unable to read at all, Daley typically gives them the label and asks if they can see the print OK. If they answer, "No," then she knows they may be illiterate and will need other means of instruction, such as oral or pictures. Other patients might be able to read the label but are unable to comprehend what the numbers and words mean for their diet restrictions.

In both cases, Daley will adjust the heart failure education to accommodate their needs.

"Looking at my population, probably 97% of patients had a health literacy score of zero, and what that means on the score sheet … is there's a high likelihood of 50% or more of limited health literacy," Daley says. "What you find is that people simply do not understand medical jargon, so you have to bring it down to their level of understanding."

For example, if a nurse or health educator use the word "stool," the patient might think they are speaking about something to sit on and not a bowel movement, she says.

"When I explain salt restriction to a patient with a health literacy of zero, I don't use clinical jargon," Daley explains. "I say, 'You need to cut down on salt because your body thinks your blood pressure is falling; it does not know your heart is weak, so your body starts hanging on to every particle of salt you eat or drink."

• **Teach patient how to manage his or her heart failure.** "We sit down as a family with the patient and their significant others and educate them about the type of heart failure they have and their individual risk factors," Daley says. "We teach them the early signs and symptoms they'll need to report to their physician and the importance of their diet, fluid restrictions, and daily weight monitoring."

The heart failure coach's role also includes making certain the patient has the tools needed to manage his or her care. For instance, Daley obtained grants to provide patients who are visually impaired with talking scales, and those with financial constraints with digital scales.

Daley finds that it's important to explain to patients why they must take certain actions rather than just tell them to do it.

"One of the biggest things in our transitional care program is developing a trusting relationship with patients," she says. "They know they can rely on you to be honest and tell them where they are in their disease process."

• **Assist with transition to community providers.** Most heart failure patients were admitted to the hospital under a cardiologist's care, so it's important to keep patients' community primary care physician (PCP) in the communication loop, Daley says.

"We send PCPs a formal letter in which I tell them that their patients were enrolled in the program and will be followed over the next six months," she adds. "I tell them how it's going and send them the patient's lab data, medication, and other information."

Daley arranges for a cardiac center pharmacist to conduct medication reconciliation for each patient at admission, during hospitalization, and at discharge.

"This is imperative," she says. "If the patient's medications are not correct, then the patient will have difficulty at home."

Also, the program includes home care services for most patients. All of the participating home care agencies were trained by Daley to reinforce the self-care education that is continuous across the continuum.

At eight intervals during the six months post-discharge, Daley calls patients and discusses their

diet, fluid restriction, daily weight, how to report early signs and symptoms, and whether their medication needs to be changed.

Daley makes sure patients have her hospital telephone number and that they know they can call her and leave a message at any time. She also assists them with making appointments with their PCP before they leave the hospital and asks them about these appointments at post-discharge calls.

She discusses their current health issues and reinforces their discharge instructions and education.

"I might say, 'You told me about your problem. We discussed it, and so when we hang up you're going to call your health care providers and discuss this with them, and if there's a problem you can get back to me,'" Daley explains. "A lot of our elderly patients have great difficulty in bothering a doctor, and sometimes they just need permission in doing this."

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SOURCE

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SNFs often have high number of readmissions

INTERACT intervention can help

Research has shown that close to one in four Medicare patients transitioned from the hospital to skilled nursing facilities are readmitted to the hospital within 30 days. This is less than ideal, especially in these times when hospitals and other providers have to meet a growing list of federal quality standards.[1]

This revolving door of rehospitalization cost Medicare $4.34 billion in 2005 and increased the likelihood of medical errors related to care coordination, a study found.[1]

A new study also found a high percentage of readmissions from skilled nursing facilities (SNFs), suggesting the problem is common and related to both an elderly population and a lack of attention to transitional care initiatives.[2]

"Our study looked at one elderly population

CNE questions

9. The proposed rule for accountable care organizations by the Centers for Medicare & Medicaid Services contains 65 quality standards in five areas. Which of the following two areas are included?
   A. patients' care experience and extent of care continuum;
   B. patient safety and emphasis on preventive health;
   C. success in treating Medicare beneficiaries who are sick and frail and cost savings;
   D. Both A and B

10. A new study about hospital post-discharge calls to patients from the University of Texas School of Biomedical Informatics at Houston and Memorial Hermann Healthcare System in Houston found that the calls impacted outcomes in which of the following ways:
   A. Readmission rates were lower for patients who received the telephone follow-up.
   B. Patient satisfaction survey return rates were higher for people who received the follow-up call.
   C. Patient satisfaction ratings were unchanged.
   D. All of the above

11. A screening tool for heart failure patients predicts which patient is more likely to be readmitted to the hospital. How many of the following risk factors need to be present to be indicative of readmission risk? Here are the risk factors: Was the patient admitted to the hospital two or more times in the past year? Did the patient have any two items within a set of Adhere Cart Criteria? Did the patient have a heart failure readmission within 30 days? Was the patient's ejection fraction less than or equal to 30%? Were there two of the three following comorbidities of renal failure, chronic obstructive pulmonary disease (COPD), or anemia? Was the patient newly diagnosed with heart failure?
   A. One
   B. Two
   C. Three
   D. Four

12. In a study by Ouslander, et al, how many patients ages 75 and older who were discharged from the hospital to a SNF were readmitted within 30 days?
   A. one in four
   B. one in five
   C. one in ten
   D. one in twenty

Answers: 9. D; 10. D; 11. A; 12. B

almost exclusively Caucasian in a non-teaching community hospital that does not have any vertical integration or own a skilled nursing facility," says **Joseph G. Ouslander**, MD, associate dean and professor in the medical school of Florida Atlantic University in Boca Raton, FL.

The new study found that one in five patients, ages 75 and older, who were discharged from the hospital to a SNF were readmitted to the hospital within 30 days, and one-third of the readmissions occurred within just one week of discharge.[2]

"We had two to three key findings," Ouslander says. "The most important involved the diagnoses associated with hospitalizations and rehospitalizations, and a large hunk of these were due to cardiovascular conditions, infections, and renal failure — probably due to electrolyte imbalance and dehydration."

Investigators highlight the need for SNFs and providers working to make safe transitions in care to follow existing care protocols and care pathways for managing these conditions.

"One of the main things that this study points out is, you will get a big bang for the buck if you have hospitals working with nursing homes on care protocols for those conditions," Ouslander says.

Another finding was that most of the time the patient's readmission diagnosis was different from the initial admission hospital diagnosis, he notes.

For example, when data on patients with congestive heart failure were pulled, investigators found that 60% of the time their readmissions were for diagnoses other than heart failure, he adds.

"I think that points to the complexity of these patients," Ouslander says. "They have multiple conditions that can exacerbate each other."

Both Ouslander's and previous research point to transition problems and breakdowns in education and continuum of care. The easiest solution is for hospitals, SNFs, and other community providers to follow existing interventions and improve their communication and education efforts.

The Intervention to Reduce Acute Care Transfer (INTERACT) is an example of an intervention that could improve hospital-to-SNF transitions.

Ouslander's group developed INTERACT as a quality improvement program for nursing homes with tools and strategies for identifying conditions early and trying to manage them in the nursing home. The intervention also has some educational material and tools for hospitals, as well. These are available for a free download at the INTERACT website: http://interact2.net/tools.html.

One of the nursing home tools is an early warning tool that offers brief instructions to nursing home staff. It asks staff if they have identified an important change while caring for a resident and to circle the change and discuss it with the charge nurse before the end of their shift.

The INTERACT II Tools, educational materials, and implementation strategies were developed by Ouslander, Gerri Lamb, MD, Alice Bonner, MD, Ruth Tappen, MD, and Laurie Herndon, MD, with input from direct care providers and national experts in a project supported by the Commonwealth Fund based at Florida Atlantic University.

Initial versions of the INTERACT Tools were

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 this 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.

COMING IN FUTURE MONTHS

- Strategies for improving communication with other providers
- How do you select the best sub-acute care facilities?
- Home care referrals grow, leading to new transition strategies
- Hospital's transitional care model is best practice

developed by Ouslander and Mary Perloe, MS, GNP, at the Georgia Medical Care Foundation with the support of a special study contract from the Centers of Medicare & Medicaid Services.

The instructions follow the acronym STOP AND WATCH:

- Seems different than usual
- Talks or communicates less than usual
- Overall needs more help than usual
- Ate less than usual
- Not because of dislike of food
- Drank less than usual
- Weight change
- Agitated or nervous more than usual
- Tired, weak, confused, or drowsy
- Change in skin color or condition
- Help with walking, transferring, toileting more than usual.

Another tool, called the Nursing Facilities Capability List, provides hospitals with a way to assess a nursing facility's ability to handle patients with different medical needs.

"This tool is so the hospital can know what the nursing home is capable of doing, and it's to promote good communication both verbally and in writing," Ouslander says.

"We also have some educational material on advance care planning because some rehospitalizations are people in the end stages of life, and they haven't elected to have comfort care or hospice care yet," Ouslander says.

Another strategy that would help improve hospital-to-SNF transitions is better use of health information technology so that critical data are readily available to people during the transition period.

"Having links between hospital electronic records and nursing homes is important so that people in nursing homes can see the critical information," Ouslander suggests. "Also, there should be more phone calls between doctors or from nurse practitioners to doctors to ensure that when someone is being discharged their care is being followed critically."

A third strategy is to have hospitalists follow patients into SNFs to provide continuity of care, he says.

"The major caveat is that hospitalists normally are not trained in geriatrics and long-term care," Ouslander notes.

"The American Directors Association, representing several thousand medical directors of nursing homes, is working on developing competencies for physicians and nurse practitioners who work in nursing homes," he adds. "Hospitalists working in collaboration with nurse practitioners could really improve the transition and continuity of care and reduce readmissions."

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1. Mor V, Intrator O, Feng Z, et al. The revolving door of rehospitalization from skilled nursing facilities. *Health Aff* (Millwood). 2010:29(1):57-64.
2. Ouslander JG, Diaz S, Hain D, et al. Frequency and diagnoses associated with 7- and 30-day readmission of skilled nursing facility patients to a nonteaching community hospital. *J Am Med Dir Assoc* 2011;12(3):195-203.

SOURCE

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DISCHARGE PLANNING
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CNE Evaluation: Please take a moment to answer the following questions to let us know your thoughts on the CNE program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your certificate.**

CORRECT ● **INCORRECT** ⊘ ✓ ✗ ⊗

1. If you are claiming nursing contact hours, please indicate your highest credential: ○ RN ○ NP ○ Other _____

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
After participating in this program, I am able to:						
2. Identify particular clinical issues affecting discharge planning.	○	○	○	○	○	○
3. Apply discharge planning regulations to the process of discharge planning.	○	○	○	○	○	○
4. Describe how the discharge planning process affects patients and all providers along the continuum of care.	○	○	○	○	○	○
5. Cite practical solutions associated with the discharge planning process based on independent recommendations from clinicians working in the field or from specific regulatory bodies.	○	○	○	○	○	○
6. The test questions were clear and appropriate.	○	○	○	○	○	○
7. I detected no commercial bias in this activity.	○	○	○	○	○	○
8. This activity reaffirmed my clinical practice.	○	○	○	○	○	○
9. This activity has changed my clinical practice.	○	○	○	○	○	○

If so, how? _____

10. How many minutes do you estimate it took you to complete this entire semester (3 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers to the correct ones listed. _____ minutes.

11. Do you have any general comments about the effectiveness of this CNE program?

_____

I have completed the requirements for this activity.

Name (printed) _____ **Signature** _____

Nursing license number ***(required for nurses licensed by the state of California)*** _____