HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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Look beyond your hospital walls to prevent readmissions

It takes a 'village' to ensure a successful discharge

As a hospital case manager, you may think your job is done when you ensure that your patients have a discharge plan and have left the hospital. In today's healthcare environment, that is not enough. Hospitals have to extend their reach beyond the hospital walls and work with post-acute providers and caregivers to ensure a successful discharge.

"Traditionally, we have tried to optimize care within the settings in which we work. If we really focus on patients and caregivers, we need to think about the patient experience over time and keep in mind that the team is not just the people within the walls on the hospital. It's all the people who provide care for the patient at all levels of care who need to work together to improve patient care," says **Pat Rutherford**,

Joining Hands to Prevent Readmissions

It's no longer enough for hospitals to concentrate their readmission prevention efforts on what goes on inside the hospital walls. As the Centers for Medicare & Medicaid Services and other payers start to issue penalties for excess readmissions, hospital case managers need to collaborate with their counterparts at other levels of care to ensure that patients have a successful discharge. In this issue, we examine the whys and hows of communitywide discharge collaborations and look at what hospitals are doing to join hands with post-acute providers. We'll give you tips for improving your internal discharge processes and teaming up with community providers to prevent readmissions. You'll learn how one hospital slowly built liaisons with community providers, how one hospital joined hands with the Visiting Nurse Association, and how two hospitals partnered with their local Agencies on the Aging to provide post-acute follow up.

RN, MS, vice president at the Institute for Healthcare Improvement, a non-profit organization based in Cambridge, MA, that focuses on innovation and collaboration in improving healthcare. *(For Rutherford's tips on improving the discharge process within the hospital, see related article on page 131.)*

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Next month, the Centers for Medicare & Medicaid Services (CMS) is going to start penalizing hospitals for excess readmissions within 30 days of patients with heart failure, pneumonia, and acute myocardial infarction and has announced plans to add more diagnoses to the list. In addition, in fiscal 2015, Medicare spending-per-beneficiary will be added to the CMS Value-based Purchasing Program. The measure, designed to evaluate how efficiently care is delivered when patients are in the hospital and the effectiveness of the discharge plans they develop, includes every Medicare Part A and Part B claim incurred by the patient beginning three days before discharge through 30 days after discharge.

Both of these initiatives mean that hospitals need to shift from the concept that when patients leave their four walls, they are no longer the hospital's problem, says **Robin Jones**, RN, quality improvement coordinator at Valley Baptist Medical Center in Brownsville, TX.

"We can create the best discharge plan in the world, but if we didn't have a partnership with downstream providers to assure a safe transition and if there are not community resources available to meet patient needs, it is likely that patients will come back," Jones adds. *(For details on the hospital's participation in the Rio Grande Valley Readmission Coalition, a collaboration of nine hospitals and the Agency on Aging, see related article on page 139.)*

Everybody along the continuum of care — the office practices, skilled nursing facilities, home health agencies, and other post-acute providers — have a part in reducing hospital readmissions, Jones says. "We are all in this together, and it

EXECUTIVE SUMMARY

Instead of limiting their efforts to what happens while patients are in the hospital, case managers need to reach out to community providers and make sure patients have everything they need to prevent a readmission.

- Next month, CMS begins penalizing hospitals for excess readmissions.
- It takes collaboration with downstream providers to ensure a successful transition to the community.
- Communication between levels of care is essential in preventing readmissions.
- Start by taking a hard look at your discharge process and collaborating within the hospital to make improvements.

takes an effort on everyone's part to engender a collaborative spirit," she says.

To ensure that patients are not readmitted, hospitals have to open up the lines of communication with post-acute providers, says **Bonnie Kratzer**, RN, director of care management, home health and hospice at Charles Cole Memorial Hospital in Coudersport, PA, a critical access hospital in rural Northern Pennsylvania. "Everyone who is caring for the patient at all levels of care need to work together with a common goal in mind. If you work in silos instead of working together, the discharge plan could fall apart," Kratzer says. *(For details on Charles Cole Memorial's initiatives, see related article on page 133.)*

She advises hospitals to take the first step and reach out to community providers. "We have to start somewhere if we are going to take care of the patients we serve and collaborate with all the providers in the community, even if they may be competitors in some way. We need to keep things open and put the patient first," she says.

Case managers often communicate regularly with their counterparts in skilled nursing facilities or home health agencies, but in most cases, they don't truly join efforts and work together, Rutherford says. However, since hospital case managers generally have good relationships with post-acute providers, they are in a good position to create the bridge between the hospital and the community providers, she says.

"Clinicians and staff can create cross-continuum 'teamness' by working together to promote individualized and coordinated care. The first step in developing this new level of collaboration is to identify problem areas and seek joint solutions without blaming or power-brokering," she says. Often, staff at home health agencies and skilled nursing facilities are reluctant to bring up problems because they count on the hospital for referrals, she says. "It is time for health care providers to join forces to create 'one team' to provide the very best care for patients in our care," she adds.

UConn Health Center/John Dempsey Hospital, Farmington, CT, had limited success when it invited post-acute providers to collaborate on a readmission reduction program, says **Wendy Martinson**, RN, BSN, QA specialist in the clinical efficiency and patient safety department. But now, providers are actually asking to join in the efforts, she adds. *(For a look at how the committee works, see related article on page 132.)*

Jones adds that collaborations with post-acute providers not only help improve transitions but they help the hospital learn about which providers have disease-specific programs and expertise in certain areas.

"We know that we have a better chance at a successful discharge if we give patients a list of facilities that have the expertise to meet their specific needs rather than giving them a generic list. If we know what services providers specialize in and if the facility is accredited, we can give patients the information they need to make an informed decision," she says. ■

Improving discharges starts within the hospital

Focus on patient-centered initiatives

According to *Pat Rutherford*, RN, MS, vice president at the Institute for Healthcare Improvement, hospitals can improve patients' discharge from the hospital by enhancing current discharge processes and by making the following changes:

- Gain a deeper understanding of the comprehensive post-discharge needs of the patient through an ongoing dialogue with the family, caregivers, and community providers.
- Gain a deeper understanding of patient and family caregiver comprehension of the clinical condition and self-care needs after discharge.
- Develop a post-acute care plan based on the assessed needs and capabilities of the patient and family caregivers.
- Effectively communicate post-acute care plans to patients and community-based providers of care.

Rutherford leads the IHI's State Action on Avoidable Rehospitalizations (STARR) initiative, which aims to reduce rehospitalizations by catalyzing a multi-state, multi-stakeholder approach to dramatically improve the delivery of effective care on a regional scale, working across organizational boundaries. "Our 'North Star' in the STAAR initiative is facilitate a safe, effective, and patient-centered transition from the hospital to the next settings of care. While removing waste and inefficiencies from our healthcare system is an essential task for reducing unneces-

sary healthcare costs, improving care transitions and reducing avoidable readmissions is first and foremost a patient-centeredness initiative," she says.

The frontline nursing staff, doctors, case managers, and social workers can work together to develop a comprehensive assessment of patients' home-going needs. Rutherford recommends asking patients and family caregivers what they are most worried about when they leave the hospital. "Including patients, family caregivers, and community providers in the discharge process takes more time but yields critically important information that enhances planning," she says.

She recommends using "teach-back" to supplement current patient education methods throughout the hospital stay. "The use of teach-back helps clinicians assess patients' and family caregivers' understanding of the discharge instructions and their ability to perform self-care," she says. She suggests that the hospital staff consider partnering with providers in all clinical settings to standardize patient-friendly educational materials.

Expand the scope of your multidisciplinary rounds to include in-depth planning to initiate services based on the needs and capabilities of patients and caregivers and to mitigate circumstances that could cause a readmission. The case managers and the discharge coordinator should have key roles in this initiative, she says.

Provide real-time critical information at the time of discharge to providers in community settings to make sure critical information is available to doctors and advances practice when a patient calls with a problem at 2 a.m. the day after the patient has been discharged from the hospital. "A simple one-page summary co-designed by the senders and receivers is ideal," Rutherford says. Make sure the discharge instructions you give patients and family members are clear and easy to understand.

Telephone follow-up is a common intervention to improve transitions and reduce hospital readmissions, Rutherford points out and cautions that "it takes a coordinated effort to effectively plan follow-up calls to be effective, and one-size doesn't fit all." She tells of one patient who said she preferred the post-discharge follow-up call from the doctor or nurse from the hospital and another one who thought it would be more helpful if his physician office made the call.

"Important considerations include: who is in the best position to reinforce the discharge instructions and to help with problem-solving; how the phone conversation is conducted; and what form of documentation and information sharing after each call to ensure care coordination," she says.

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IHI has published a how-to guide for hospitals: Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2012. Available at www.IHI.org. ■

Meetings help improve patient transitions

Providers bond, improve transitions

When UConn Health Center/John Dempsey Hospital in Farmington, CT, first proposed meetings with post-acute providers to improve transitions, only two skilled nursing facilities and a few home health agencies agreed to participate.

"It was slow going at first. Since the emphasis on preventing readmissions has come to the forefront, we have people asking to join

EXECUTIVE SUMMARY

It took a while to get started, but UConn Health Center/John Dempsey Hospital in Farmington, CT, is now meeting monthly with dozens of post-acute providers to work on improving transitions.
• Providers exchange ideas for better patient care.
• Educational materials have been standardized throughout the continuum.
• Based on input from other providers, the hospital is improving the discharge materials.

the committee," says **Wendy Martinson**, RN, BSN, QA specialist in the clinical efficiency and patient safety department. Now there are representatives from 14 skilled nursing facilities, 14 home care agencies, two assisted living facilities, a durable medical equipment and oxygen supplier, a community agency that works with the elderly, and an insurance carrier on the committee. Other organizations that are joining the group include an adult day care provider and a patient advocate.

"Knowing what it's like for post-acute providers has been an eye-opening experience that we have used to improve hospital processes. These meetings have helped foster a true collaboration of working better together across the continuum of care. This team of providers who work throughout the continuum are a dedicated group of people who are really invested in ensuring quality of care," she says.

The hospital started the meetings with the home health agencies and skilled nursing facilities based on common referrals and gradually expanded to include other post-acute providers.

"When we first started the meetings, we feared that it would be a finger-pointing session; however, that truly was not the case. Blame has never entered any of the meetings. We immediately became a cohesive group and with everyone working for the same objective," she says.

The committee meets once a month to address issues that arise as patients transition from one level of care to another and collaborate on ways to improve the quality of care. "We knew that we could definitely improve on communication across settings. Everybody tends to work in their own silo, but we individual providers can't improve transitions alone," Martinson says.

The committee agreed that all providers would use the same educational materials throughout the continuum. They assembled a variety of educational booklets, showed them to patients, and then agreed that all providers would use the materials that the patients preferred.

Based on input from the post-acute providers, the hospital embarked on a quality improvement project to revise the discharge materials to make sure the providers were getting the information they needed. "We are working on increasing the information provided in our discharge instructions, and getting the dictated discharge summaries to providers, specifically the visiting nurse agencies, in a timely manner," she says.

As a result of the meetings, the nurses who care for the patient in the hospital make a verbal report to the staff at the next level of care in addition to the discharge forms sent by the hospital. Social workers also make a report to the next level of care if they have identified social issues. "Sometimes there are family dynamics or other issues that the staff doesn't want to put on paper but that will help the staff at the next level formulate the best plan of care. It's worked well for the nurses and social workers to make the reports by telephone," she says. ■

Community collaboration helps cut readmits

Rural hospital partners with post-acute providers

By improving processes within the hospital and collaborating with post-acute providers in the community, Charles Cole Memorial Hospital in Coudersport, PA, decreased its 30-day readmission rate for all patients by 15.9% in a one-year period.

The critical access hospital, located in a rural area in North Central Pennsylvania, is licensed for 49 beds and has an average daily census of around 25 patients. Cole Memorial and its ten community health care centers serve more than 60,000 residents within a 65-mile service area including Potter, Cameron, McKean, and Tioga Counties in Pennsylvania and New York's Southern Tier.

The hospital originally planned to collaborate with the Pennsylvania Area Agencies on the

EXECUTIVE SUMMARY

Charles Cole Memorial Hospital in Coudersport, PA, slashed its readmission rate by 15.9% by collaborating with post-acute providers and making internal improvements.

- Community transition team members educate each other on what happens at each level of care.
- Team worked together to standardize educational materials and improve communication between providers.
- Internal measures include revising educational process and improving medication reconciliation.
- Eligible patients are referred to Pennsylvania Area Agencies on Aging for follow-up after discharge.

Aging to apply for a Community-Based Care Transitions grant from the Centers for Medicare & Medicaid Services' (CMS) Partnership for Patients but determined that the collaboration did not qualify because grant funds are not available to benefit patients discharged from critical access hospitals.

"We decided to move forward anyway because we knew a partnership with community agencies would be beneficial to the community residents we serve and every organization involved," says **Cynthia Hardesty**, RN, vice president and chief nurse executive.

The hospital had been working on ways to reduce readmissions and meet patient needs throughout the continuum for some time, reports **Kris Zitnik**, RN, BSN, CIC, director of quality management. "We were working on improving processes within the hospital, but we also knew that because hospital stays are very short and patients typically are not fully recovered when they are discharged, we had to involve other providers in the community as well," she adds.

The hospital put together a community transitions team led by **Bonnie Kratzer**, RN, director of care management, home health and hospice, and began having monthly meetings with other community providers to discuss ways to improve transitions and prevent readmissions. Representatives from the hospital's own skilled nursing facility and home health agency participated, along with other skilled nursing facilities, personal care homes, pharmacies, home health agencies, and representatives from the Pennsylvania Area Agencies on the Aging in the hospital's service area.

The communitywide transitions task force had its first meeting in July 2011 and continues to meet monthly. "At the first meeting, we realized that the community partners had no knowledge of what we were doing as a hospital to prevent readmissions and that we needed to be educated about the role of the post-acute providers and what happens when they take over care of the patients," Kratzer says.

In the beginning, the participants took turns presenting information and education about their organization and how it works. "Along with learning about each other, we cut down the silos and became friends. Some of us were still competitors but we started to work together and put patients first," Kratzer says.

In the early meetings, the group worked together to develop a standardized transition form that the hospital uses when patients are transferred to a skilled nursing facility or referred for home health services. The team also created a form for the skilled nursing facilities to use when patients are discharged with home care.

"When we started, everybody had their own form and their own needs. We worked together to mesh all of the information everybody needs into one form. It makes the discharge process simpler and we know that the next provider has the information they need to immediately start providing care for the patient," Kratzer says.

When the nurse case managers from the Agencies on the Aging reported that the medication lists they received from the hospital were hard to read, they worked with the hospital case managers to improve them. They reported on what problem areas they found when they visited the patient homes and brainstormed on how the hospital could improve the discharge plan. The Agency on the Aging shared educational materials from other hospitals and worked with the Cole Memorial staff to standardize patient education.

"We work closely with the Pennsylvania Area Agencies on Aging to enroll eligible patients who need additional support after discharge in their program. In addition, if our hospice or home care staff report an issue in the home such as a frail patient living alone, someone with no food in the home or disconnected utilities, they refer the patient to the Agency on the Aging in that area for assistance," Kratzer says.

When some patients reported during follow-up calls that they couldn't get their prescriptions filled because the pharmacy was closed when they were discharged or that the medication they were prescribed wasn't in stock, the hospital pharmacists and representatives from the retail pharmacists on the task force worked together on changing the medication formularies.

Internally, the hospital staff reviewed the charts of patients who were readmitted and looked for opportunities to improve processes. For instance, the team improved the education the nurses were giving the patients and tweaked its medication reconciliation process.

When data showed that patients who went home with a follow-up appointment two weeks later often returned to the hospital before

CASE MANAGEMENT INSIDER
Case manager to case manager

The Role of Case Management in an Era of Healthcare Reform — Part 3

By **Toni Cesta**, PhD, RN, FAAN
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In the last two issues, we discussed some of the topics related to health care reform that are of greatest interest to case management professionals. This month's Case Management Insider continues this discussion with a look at patient satisfaction, mortality measures, and the new efficiency of care measure.

The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey

HCAHPS is classified as an "outcome" measure for purposes of measurement under value-based purchasing. Since July 2007, hospitals subject to the Inpatient Prospective Payment System (IPPS) annual payment update provisions must collect and submit HCAHPS data in order to receive their full IPPS annual payment update. IPPS hospitals that fail to publicly report the required quality measures, which include the HCAHPS survey, may receive an annual payment update that is reduced by 2.0 percentage points. The Patient Protection and Affordable Care Act of 2010 includes HCAHPS among the measures to be used to calculate value-based incentive payments in the Hospital Value-based Purchasing Program, beginning with discharges in October 2012.

HCAHPS is important because it is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. It is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience. While many hospitals have collected information on patient satisfaction for their own internal use, until HCAHPS there was no national standard for collecting and publicly reporting information about patient experience of care that allowed valid comparisons to be made across hospitals locally, regionally and nationally.

HCAHPS Content and Administration

The HCAHPS survey asks discharged patients 27 questions about their recent hospital stay. The survey contains 18 core questions about critical aspects of patients' hospital experiences (communication with nurses and doctors, the responsiveness of hospital staff, the cleanliness and quietness of the hospital environment, pain management, communication about medicines, discharge information, overall rating of hospital, and would they recommend the hospital). The survey also includes four items to direct patients to relevant questions, three items to adjust for the mix of patients across hospitals, and two items that support congressionally mandated reports.

The HCAHPS survey is administered to a random sample of adult patients across medical conditions between 48 hours and six weeks after discharge; the survey is not restricted to Medicare beneficiaries. Hospitals may either use an approved survey vendor or collect their own HCAHPS data (if approved by CMS to do so). HCAHPS can be implemented in four different survey modes: mail, telephone, mail with telephone follow-up, or active interactive voice recognition (IVR).

HCAHPS and Case Managers

Hospitals can use the HCAHPS survey alone, or include additional questions after the core HCAHPS items. Hospitals must survey patients throughout each month of the year. Case management departments should take a look at the questions that their hospitals are using and be sure that they reflect the roles and functions of their case managers and social workers. Some hospitals may choose to add additional questions that more greatly reflect the roles of the social workers and case managers but do so with the understanding that there will be no national database comparison of the questions. It is important that case management professionals are not held accountable for questions that are not directly related to their work.

Mortality Measures

Mortality measures are another example of the CMS "outcome" measures. The three mortality models estimate hospital-specific, risk-standardized, all-cause 30-day mortality rates for patients hospitalized with a principal diagnosis of heart attack, heart failure, and pneumonia. These are the only diagnoses identified by CMS for this measure at this time. All-cause mortality is defined as death from any cause within 30 days of the "index admission" date, regardless of whether the patient dies while still in the hospital or after discharge. An index admission is the admission with a principal diagnosis of a specified condition that meets the inclusion and exclusion criteria for the measure.

For each condition, the risk-standardized ("adjusted" or "risk-adjusted") hospital mortality rate can be used to compare performance across hospitals. The mortality measures for heart attack, heart failure, and pneumonia have been endorsed by the National Quality Forum (NQF), the non-profit public-private partnership organization that endorses national healthcare performance measures.

The CMS mortality measures assess all-cause mortality; that is, they consider deaths for all reasons, not just due to the underlying principal diagnosis. There are several reasons for this choice of outcome. First, from the patient perspective, death from any cause is the key outcome. Attributing mortality to a cause other than heart disease may provide little solace to patients and their families. Second, it is often hard to exclude quality issues and accountability based on the documented cause of death. For example, a patient with heart failure who develops a hospital-acquired infection may ultimately die of sepsis and multi-organ failure. It would be inappropriate to consider the death as unrelated to the care the patient received for heart failure. Another patient might have a complication leading to renal failure, resulting in death that is related to that event and yet quality of care could have reduced the risk of the complication. It is true that this approach will include some patients whose event is truly unrelated to their care. A patient, for example, could be involved in a motor vehicle accident after hospital discharge and the institution could reasonably claim to have had no role in the event. Nevertheless, events completely unrelated to the admission are expected to be uncommon and should not be clustered unevenly among hospitals.

Inclusion and Exclusion Criteria for Acute MI and Heart Failure

The CMS 30-day Mortality Measures for AMI and HF include fee-for-service Medicare enrollees with a principal discharge diagnosis of AMI (for AMI calculations) or HF (for HF calculations) at least 65 years of age at the time of their admission who were enrolled in fee-for-service Medicare during their admission and for at least one year prior to their admission.

Exclusion from this measure is based on the following criteria:

- less than 65 years old;
- cases with a length of stay of ≤ 1 day discharged alive (and not discharged against medical advice or transfer);
- AMI or HF; Cases with a total length of stay exceeding one year;
- patients admitted to your hospital who were transferred in;
- AMI admissions for patients who had been previously admitted to your hospital or another hospital and died within.

Case Managers and Mortality Measures

The mortality outcome measure is another example of a measure that may not be directly related to the work of case management professionals but is important to understand. Under value-based purchasing, in federal fiscal year

2014, mortality measures will be used as one of the indicators for payment incentives to hospitals. Case managers and social workers can play a part in assisting patients and families at end of life so that they may select the most appropriate plan of care that meets their needs and capabilities. This may include end-of-life care at home with home hospice, sub-acute or long-term care settings with hospice programs. The destination selected must meet the wishes and capabilities of both the patient and the family and should be clearly articulated and explained to them so that the right decisions can be made.

The New Efficiency of Care Measure — Also Known as Spending per Beneficiary

Of all the measures we have discussed, the efficiency of care measure may have the greatest significance to case managers and social workers. The goal of this measure is to encourage hospitals to be more cost-efficient — looking for a lower number than a higher number in this case. CMS also describes this measure as the resource use measure and describes how this measure will be translated in practice by describing the following elements:

Resource use when combined with quality metrics will help Medicare to:

- encourage the highest outcomes for the lowest cost;
- identify the most efficient providers, systems of care, and regions;
- prevent overuse and inappropriate use of health services;
- improve the value of Medicare for beneficiaries and taxpayers.

By improving efficiency, the potential exists to reduce the rate of growth of health care costs while improving the value of that care at the same time.

Efficiency Defined

Efficiency is defined as the interaction between the resources used to deliver care and the quality of the care that is delivered. To accomplish the goal of delivering high-quality, lower-cost care requires quality and resource metrics. The baseline period for this measure was between 5/15/10 and 2/14/11. During the baseline period CMS assessed Part A and Part B beneficiary spending during a "per beneficiary" episode.

The most important change is that the "beneficiary episode" will now span from three days prior to a hospital admission through 30 days after discharge. Included in this 30-day period are transfers, readmissions and additional admissions. The measure is adjusted for age and severity of illness.

Because case managers play such an important role in resource management, it is important to understand how CMS will be defining resources. CMS is mainly focused on metrics associated with episodes of care. They define episodes of care as a series of separate but clinically related services delivered over a defined time period. Resources used in episodes of care are defined as the program costs as opposed to the costs that providers incur to deliver the services. They include both the Medicare program and the beneficiary payment.

The Spending per Hospital Patient with Medicare measure shows whether Medicare spends more, less, or about the same per Medicare patient treated in a specific hospital, compared to how much Medicare spends per patient nationally. This measure includes any Medicare Part A and Part B payments made for services provided to a patient during the three days prior to the hospital stay, during the stay, and during the 30 days after discharge from the hospital.

This result is a ratio calculated by dividing the amount Medicare spends per patient for an episode of care initiated at the hospital by the median (or middle) amount Medicare spent per patient nationally.

A result of 1 means that Medicare spends ABOUT THE SAME amount per patient for an episode of care initiated at this hospital as it does per hospital patient nationally.

A result that is more than 1 means that Medicare spends MORE per patient for an episode of care initiated at this hospital than it does per hospital patient nationally.

A result that is less than 1 means that Medicare spends LESS per patient for an episode of care initiated at this hospital than it does per hospital patient nationally.

For this measure lower numbers are better.

CMS "Dry Run" of Imaging Efficiency Measures

The Centers for Medicare & Medicaid Services (CMS) conducted a national "dry run"

of reporting data for four Outpatient Imaging Efficiency (OIE) measures included in the Hospital Outpatient Quality Data Reporting Program (HOP QDRP). Throughout the 30-day dry run, which ended on March 18, 2012, hospitals were able to submit questions or comments regarding the Hospital Specific Report.

The four outpatient imaging tests being evaluated include:

- MRI Lumbar Spine for Low Back Pain
- Mammography Follow-Up Rates
- Abdomen CT Use of Contrast Material
- Thorax CT Use of Contrast Material

Implications for Case Management

Conceptually, this measure has broad implications for case managers and other health care professionals engaged in managing care processes and resource utilization. Consider the scenario of a patient seen in her physician's office two days prior to admission. The physician orders several diagnostic tests for the patient to have done, including a chest X-ray to rule out pneumonia. The patient has the tests and the physician determines that she does have pneumonia. He contacts the patient, who reports that her shortness of breath has worsened and that she has a temperature of 101° F. He directs the patient to go to the hospital's emergency room for evaluation and possible admission.

The patient goes to the emergency room where, in today's health care delivery system, the chest X-ray would probably be repeated. Additional tests already completed prior to arrival to the emergency room would also probably be repeated. After the tests are repeated, the patient is admitted to the hospital, where the pneumonia is treated with intravenous antibiotics. The patient is then discharged home with home care and infusion therapy. The home care agency will then follow the patient for several weeks as she completes her course of IV antibiotics.

In a bundled payment methodology scheme such as CMS is proposing under the new efficiency measure, the tests that the physician ordered from his office, the tests done in the emergency room, the treatment in the hospital, and the home care treatment would all be "bundled" into one payment.

Communication Is Essential

Under a bundled payment system, it will be essential that all interdisciplinary care team members are in communication as the patient transitions throughout the continuum of care. Case managers will play a key role in ensuring that pre-admission tests and results are communicated so that costs can be optimized and test results can be used regardless of the patient's location. Case managers will need to be embedded in the community as well as in the emergency department to make this as seamless as possible. Through electronic data exchange systems, case managers will be able to receive alerts when patients arrive in various locations along the continuum of care. A community-based case manager can alert the ED case manager of a patient and the diagnostic testing and/or treatments initiated in the community can be reviewed so that they are not replicated.

Reducing replication of services serves multiple purposes. It clearly reduces cost. In addition, it reduces patients' exposure to unnecessary radiology testing and other tests that may have long-term negative effects on patients. In addition, reducing testing and other procedures should increase throughput. If the physician obtains testing done out-patient in the prior 24 hours, then diagnosis and treatment can be initiated more quickly,

Summary

It is CMS's contention that this efficiency measure will positively impact on both cost and length of stay. It will do this by accomplishing all the goals listed above. Length of stay should be decreased as patients are treated more rapidly. Faster treatment means improved quality of care and less opportunity for adverse events to occur such as falls, medication errors or infections. In addition, if pre-admission and post-discharge costs and interventions are taken into consideration as part of a "package of services," compartmentalization of services is less likely to occur and patients will be less likely to be exposed to unnecessary tests, treatments and procedures. This shift in reimbursement, like other shifts before it, will hopefully result in a system that considers patient events regardless of where they happen across the health care continuum. ■

their primary care visit, the hospital made sure that patients got follow-up appointments in a short time period after discharge. To make sure patients don't experience difficulties in getting a timely follow-up appointment with a primary care physician, the nursing staff arranges the appointments while the patients are still in the hospital. "It's more effective if an appointment is made before the patient leaves. Hospital personnel can make a point with the physician office staff that the patient needs to be seen within a few days," Kratzer says. The surgical services began making follow-up appointments for patients at the same time they scheduled elective surgery.

The major key to the success of the program is to keep trying different ways to make the processes work, Hardesty says. One example is the initiative to make follow-up calls to patients after discharge to make sure they have everything they need and understand their discharge plan. Initially, the case managers made the calls, but when they were busy the calls fell through the cracks. Then, the quality management nurse and the director of acute care tried making the calls, but sometimes they were too busy. Now the supervisors make the calls as they are close to the point of care.

"We felt this was important, so we kept plugging away. It takes persistence to get the right processes in place. The more you keep talking about it, the more everybody understands the big picture. Just bringing the community providers together has helped put improving patient care and preventing readmissions on everybody's radar," Hardesty says. ■

Nine hospitals collaborate to prevent readmissions

Partnership includes Agency on Aging

Nine hospitals in southern Texas have joined with the area's Agency on the Aging and formed the Rio Grande Valley Readmission Coalition to follow at-risk patients after they are discharged from the hospital in an effort to prevent readmissions.

The partnership has received funds through the Centers for Medicare & Medicaid Services' Community-Based Care Transition Project, funded under the Accountable Care Act, which requires hospitals to partner with a community-based organization.

Representatives from the hospitals began meeting with the Agency on the Aging in the summer of 2011 to develop the program, says **Robin Jones**, RN, quality improvement coordinator at Valley Baptist Medical Center in Brownsville, TX.

They researched readmission reduction programs and chose the Care Transitions program, developed at the University of Colorado, which supports patients as they transition from hospital to home.

The Agency on Aging has contracted with a third-party analytic company to manage the program. All of the hospitals in the program are linked to a data exchange software program administered by a third-party analytic company. Case managers can access the web portal, which includes eligibility criteria, enter their patients' names and charts, and find out if they qualify. "This takes a lot of work off the case managers who don't have to go back to the chart and determine if patients are eligible for the program one at a time," Jones says.

When hospital case managers identify patients who are being discharged to home as being at high risk for readmissions, they refer them to the program. If the patient agrees, a health coach from the Agency on Aging who has been trained on Care Transitions interventions meets the patient before discharge and then follows up after the patient goes home. The coaches are working with 20 to 25 patients at a time.

"Patients may or may not have home health or other services at home to qualify for this

EXECUTIVE SUMMARY

The Rio Grande Valley Readmission Coalition, which includes nine hospitals and the Agency on Aging is collaborating to prevent readmissions for at-risk patients.

- Program is funded through the Community-Based Care Transition Project administered by the Centers for Medicare & Medicaid Services.
- Hospital case managers refer appropriate patients to the program and check for eligibility using a Web-based data exchange program that includes criteria for eligibility.
- Agency on Aging health coaches visit patients in the hospital and follow up for 30 days after discharge.

program. They may have had experience with a home health agency that does not have a readmission prevention program, but if they choose this agency, our hands are tied and we may feel patients need additional interventions. That's when we refer them to the program," she says.

After the patient is discharged, the coach sees the patient at home within three days and then follows up by telephone at weekly intervals during the 30 days following discharge. "They assist the patient in transitioning to home. They make sure they have their medication and understand how to take it. This program is all about teaching patients to manage their conditions and care for themselves," Jones says.

The coaches teach patients about the disease process, how to keep medication lists and sort pills, and coach them on what to ask the physician during the follow-up visit. They educate patients on when to call the doctor and when to go to the emergency department if their condition worsens.

When patients need help from community agencies, the coaches are able to help them access them through resources from the Agency on Aging's Aging and Disability Resources Center. "Our patients are able to access these resources easier because they're already entered into the Agency on the Aging system," she says. The agency has set aside some funding for Meals on Wheels, transportation and medication assistance for patients in the program who need it.

The program has fostered a close working relationship among the hospitals in South Texas, Jones says.

"Hospitals in this area often have to transfer patients within the region because they need specialty care. By collaborating, we can understand the special services each hospital provides and smooth the transitions between hospitals. We also share information with each other on our successful readmission initiatives," she adds.

By using the contracted analytic company and identifying patients by Medicare numbers, hospitals are able to track their enrolled patients' care as part of the continuum of care, no matter which hospital provides it.

"If we engage them in coaching and the patient shows up at another hospital, our case manager and the Agency on the Aging coach can work together to identify the reason for the admission and if there is something they could do differently to avoid future readmissions," Jones says. ■

Hospital, nurses team up to prevent readmissions

Initiative targets at-risk patients

In an effort to reduce readmissions, University Hospital in Newark, NJ, partnered with the Visiting Nurses Association Health Group and developed a program that uses intensive case management to reduce readmissions for patients with multiple chronic conditions.

University Hospital is the only public hospital in New Jersey. Many patients are Medicaid recipients or are self-pay and/or need charity care. "We have a large population without insurance or who have pending Medicaid applications. Many of these patients have psychosocial needs, have problems obtaining the supplies or medication they need, and/or have problems navigating the healthcare system," says **Edwin Fernandez**, RN, BSN, care coordination manager at University Hospital.

The I-Care-4-Health Transitions in Care program provides assistance for at-risk patients who have no insurance, as well as those covered by Medicaid and Medicare, says **Melissa Scollan-Koliopoulos**, EdD, APRN-BC, CDE, BC-ADM, assistant professor of medicine, division of endocrinology, diabetes, and metabolism, UMDNJ New Jersey Medical School in Newark. "Most facilities have focused on readmission for Medicare patients, but Medicaid may launch its own penalties for 30-day readmission and we want to prepare for that. It's good for the patients as well as being good for the hospital for us to make sure that patients

EXECUTIVE SUMMARY

University Hospital in Newark, NJ, and the Visiting Nurses Association Health Group are working together to provide intensive case management to Medicare and Medicaid beneficiaries and uninsured patients with multiple chronic conditions.

- Hospital case managers identify patient eligible for the program.
- Patient navigators employed by the VNA and funded by the hospital provide education while patients are in the hospital.
- Navigators visit the patients every day in the hospital and link them with primary care providers for follow up.

can be safely discharged and follow their treatment plan at home," she says.

The I-Care-4-Health team includes two navigators who are certified home health aides from the Visiting Nurses Association Health Group that the hospital funds with grants from the Robert Wood Johnson Foundation and the Healthcare Foundation of New Jersey; an RN who is a certified diabetes educator, an advanced practice nurse who is an expert in healthcare behavior, and a physician with expertise in internal medicine and diabetes.

The unit-based case managers conduct daily rounds with the multidisciplinary treatment team and identify patients appropriate for the program, Fernandez says. They assess patients for discharge needs within 24 hours of admission and work with the I-Care team to arrange whatever resources the patients will need when they leave the hospital.

The 130 patients currently in the program have one or more chronic diseases including diabetes, heart failure, hypertension, atrial fibrillation, chronic obstructive pulmonary disease, asthma, HIV, or sickle cell disease, Scollan-Koliopoulos says. Patients referred to the program have no primary care physician, which puts them at high risk for readmission because there is nobody to pick up care after discharge, she adds.

When patients are referred to the program, the patient navigators visit them in the hospital to explain the program and enroll patients who agree to participate. The patient navigators visit the patients every day in the hospital and focus on linking them with a primary care provider, either at a federally qualified healthcare center, or the hospital's clinics.

They help the patients identify resources that can pay for their healthcare and help eligible patients fill out the paperwork for Medicaid or charity care. They help patients sign up for medication assistance or other community resources that can help with their post-discharge needs. The team works with hospital physicians to make sure patients have prescriptions that qualify for the $4 prescription program at local pharmacies when appropriate. In some cases, the program provides patients with a supply of medication until the medication assistance program comes through, Fernandez says. "It's really helpful to have I-Care-4-Health on the front line to help with resources such as cab fare for office visits and equipment like crutches and walkers," Fernandez says.

The I-Care-4-Health team conducts medication reconciliation to make sure nothing falls through the cracks. For instance, patients with diabetes may have a prescription for insulin but not for syringes, according to Scollan-Koliopoulos or they can't afford to have their prescription filled.

"Some of these patients are working but may be getting paid under the table so there's no verifiable income source. Others may make a little too much for charity care and may need to find alternative care. We try to help them as much as we can to determine their barriers to receiving care and overcome them so they can develop a relationship with a primary care provider," Scollan-Koliopoulos says.

A key to the program is providing follow up with patients within 72 hours of discharge, she says. "They need help in learning which symptoms indicate they should come back to the emergency department and which can be managed at home. If nobody helps them understand, they'll come right back to the emergency department," she says.

The patient navigators reinforce the education that patients receive from the treatment team and follow up at home to make sure they understand.

"We want them to come back to the emergency department when it's appropriate and before they get so sick they need to be admitted, but we want the timing to be right," she says.

The patients have the cell phone numbers of the entire team and can call anyone any time of the day or night. "If they can't get in to see a primary care physician, we try to help them manage over the telephone or meet with them," Scollan-Koliopoulos says. ■

How mobility can shorten stay, improve outcomes

Organization started by defining mobility

Every now and then at Sunnybrook Health Sciences in Toronto, Canada, there was talk about getting ventilated patients up and about even if they were still intubated. Some people thought that the patients should be weaned off the ventilator first, some thought after, says

Linda Nusdorfer, RN, MSN, an advanced practice nurse for critical care and cardiovascular care at the facility. Still others wanted to work on weaning and mobility at the same time. But what did mobility mean? Is it passive range of motion exercises or walking?

"We would have these quality walkabouts every month, and once, we spent it asking nurses for the definition of mobility," she explains. "One of the answers was that it was using a lift to put a patient in the chair."

The idea of improving mobility — and the way caregivers thought of it — burbled along without resolution until 2011, when Nusdorfer and her colleague **Angie Jeffs**, RN, MSN, the patient care manager for critical and cardiac care, attended an Institute for Healthcare Improvement conference. "It was inspiring," Jeffs says. "When we were trained in the 1980s, we were taught to sedate ICU patients as much as possible. We were told they wouldn't want to remember they were here, and besides we should rest their lungs."

The IHI conference gave the women and the others from Sunnybrook added information and the confidence they needed to try to do something different — to get the patients up and moving as soon as possible. The potential benefits included less time being intubated, less delirium, reduced DVT risk, less potential for bed sores, and better patient and family satisfaction. "The families like to see the progress," Nusdorfer says. "The patients like to be up and around." Although there is not proof yet, she thinks they may even have a reduced rate of ventilator-associated pneumonia (VAP) because the patients spend less time horizontal, less time intubated, and have a greater degree of muscle strength that helps them clear their lungs.

Once they got back to Sunnybrook, Jeffs says they were a little overwhelmed with how to convince their peers that this was a good idea. "We chose our first candidates carefully, to make sure that they were stable," she says. "But we saw at the conference that this could be done, so we moved forward."

Two nurses, a physical therapist, a respiratory therapist, and Jeffs and Nusdorfer met regularly and started to go out as a team to identify likely candidates. "We talked to the physicians on rounds about getting people up, as well as other nurses and therapists." While the physicians were all for it, there was resistance from some nurses and therapists. "They wanted to take it slowly," Nusdorfer says.

For instance, there might be a patient in a collar who a physicians says can tolerate mobility, but somehow, it would never get done, Nusdorfer says. "PT would have to take the bull by the horns and just get that patient up." Or a patient would be up in a chair, and the nurses would argue that they were mobile, but they were being lifted into the chair mechanically. They were not using their own muscle power to do anything.

Leading by example

Having a nurse manager there to help with education was key in convincing recalcitrant people to take this chance. "We led by example," Nusdorfer says. "And then, once they saw it could be done, and the benefits that accrued to the patients, they were much more interested in getting on board." They also noted successes in a very public way — taking pictures of walking patients, celebrating the first walk down the hall, or even sitting up in a chair for the first time. They take videos of patients, and every couple months when a new batch of residents cycles through the ICU, they do an in-service education module to dismiss the myth that ventilated patients can't be mobilized.

Whenever anyone suggested that they were willing, if only there was a team that could put the idea into place, Nusdorfer informed those staff members that they were the team. "They had the best knowledge of the patient, not some group of outsiders. They were best placed to coordinate this."

Not just any patient is pulled out of bed for a saunter through the ward. Nusdorfer says they use a safe mobility tool to assess the level of consciousness in a patient, which helps determine the level of activity appropriate for the patient. It might be that one patient can dangle but isn't ready to sit in a chair, while another one, who is so soon out of surgery you don't think he or she would want to do anything but moan in bed, is raring to get up and move.

There is a database collecting pertinent information, including when is the patient medically stable, whether the patient was mobilized within 24 hours of admission or of being deemed medically stable (the definition of early mobilization), intubation data, mode of ventilation, how

much oxygen the patient was on at the time of early mobility, progression of mobility from passive range of motion to walking. They look at the resources used when walking — one nurse, two nurses, PT, RT, aide, family member, any tube losses during mobilization (to date there have been none). They are looking at whether there were any pressure ulcers at admission and on discharge, delirium rates, sedation, and restraint use.

Jeffs says a year ago, a delirious patient would have been restrained. Now, the first thing they do is get them up and moving. "The staff really sees the benefits of that." She also says they note how much more alert patients get just from sitting up. "All of a sudden their eyes get wide. It's almost like there is this synapse [that] wasn't connecting, and now it's on by helping them move." They notice, too, that the patients who are moving more are sleeping better and move more easily back into a regular routine.

Nusdorfer says they are doing a chart review now of a period from before they implemented the early mobilization program about 15 months ago so that they can compare things like pressure ulcer rates.

"Our slogan is 'Time is Muscle,'" she says. "You hear it as a cardiac phrase, but we should remember it's true for all muscle in the hospital."

For more information on this topic, contact:

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Hospital Report blog

For further analysis and discussion of topics important to hospital professionals, check out **Hospital Report**, AHC Media's new free blog at http://hospitalreport.blogs.ahcmedia.com/. Hospital Peer Review's executive editor Russ Underwood and associate managing editor Jill Drachenberg both contribute. ■

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

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

COMING IN FUTURE MONTHS

■ Why emergency department case managers are essential. How to forge bonds with your hospitalist team

■ Ensuring that appropriate patients get palliative care

■ Tips on planning discharges for the uninsured.

CNE QUESTIONS

1. When will the Centers for Medicare & Medicaid Services add Medicare spending-per-beneficiary to its Value-based Purchasing Program?
   A. Fiscal 2015.
   B. Fiscal 2014.
   C. Fiscal 2013.
   D. Time to be announced.

2. According to Pat Rutherford RN, MS, vice president at the Institute for Healthcare Improvement, discharge preparation should be a patient-centered process and should focus on doing better by patients, not just cost-containment.
   A. True
   B. False

3. According to Cynthia Hardesty, RN, vice president and chief nurse executive Charles Cole Memorial Hospital in Coudersport, PA, what was the main key to the success of the hospital's readmission reduction project?
   A. Improving relations with post-acute providers.
   B. Trying different ways to make the processes work.
   C. Revamping the discharge materials for patients and families.
   D. Working closely with pharmacists on medication issues.

4. In the Rio Grande Valley Readmission Coalition's Community-Based Care Transitions Project, how long do health coaches from the Agencies on the Aging follow patients after discharge?
   A. Six months.
   B. Three months.
   C. 60 days.
   D. 30 days.

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