HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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Don't think the Recovery Auditors will disappear

Despite scrutiny, audit program is going strong

Hospitals may eventually receive some relief from the burdens of the Centers for Medicare & Medicaid Services (CMS) Recovery Auditor (RA) program (previously called the Recovery Audit Contractor [RAC]) program — but don't think the RAs are going away.

"Hospitals can't ignore the issues at their facilities just because problems with the Recovery Auditor program are being investigated. Problems with compliance need to be addressed. Hopefully, the situation won't be so onerous for hospitals in the future, but they need to have a system in place to deal with it," says **Amanda W. Berglund**, MBA, MS, partner in Pace Healthcare Consulting, LLC with headquarters in Hilton Head, SC.

In the final months of 2012, the American Hospital Association and four hospital systems filed suit against the U.S. Department of Health and Human Services for allegedly refusing to meets its financial obligations for hospital services provided to some Medicare patients. The Medicare Audit Improvement Act (HR 6575), intended to improve the audit process and improve transparency and accuracy in the RA program and other Medicare integrity audits, was introduced in Congress, and the HHS Office of Inspector General included a review of Medicare contractors in its Work Plan for 2012. *(For details, see the January 2013 issue of Hospital Case Management.)*

Since 2009, the RA program has collected more than $3 billion in overpayments according to CMS's end-of-year report.[1] "Despite all the scrutiny the audit process is receiving, the figures justify continuing the program," Berglund adds.

If your hospital has a successful program for facilitating appropriate inpatient admissions, improving documentation and handling records requests and denials, keep doing what you're doing, suggests **Deborah Hale**, CCS, CCDS, president and chief executive officer of Administrative

Consultant Service, a healthcare consulting firm based in Shawnee, OK.

Hospitals need to be diligent about preparing for the audits and responding to them to ensure that they don't lose money they're entitled to, Hale says. The recovery auditors are looking at medical necessity, particularly for short stays, and whether there was a physician's order to admit that is dated, timed and legibly signed, Hale says. *(For specific details on RA targets, see related article on page 16.)*

That means that case managers must make sure that documentation in the medical record shows that the services provided are medically necessary and reflects the severity of illness and intensity of service as well as why the patient was admitted in inpatient status, adds **Brian Pisarsky**, RN, MHA, ACM, director in Huron Healthcare's Clinical Operations Solutions, with headquarters in Chicago.

"The number of medical record requests keeps going up, which leads to increased denials, and the RAs are adding new issues," he adds.

Some facilities are becoming overwhelmed because the RAs are issuing the maximum number of requests for medical records allowed every 45 days, Berglund says. "The recovery auditors determine what issues are problems for individual facilities and keep going after those cases," she says.

According to the American Hospital Association, hospitals that participate in the organization's RACTrac Web-based survey reported in the second quarter of 2012, that medical record requests were up 22% compared to the previous quarter, that the number of denials increased by 24%, and the dollar value was up 21% during the same period of time.

From the time the RAs began reviewing records in 2009 through 2011, Winthrop University Hospital in Mineola, NY, received 2,500 requests for records. In the first quarter

EXECUTIVE SUMMARY

Medicare's Recovery Audit program is under scrutiny from all fronts, but the program is so successful, it's not going to go away, so hospitals need to continue to prepare.

- Make sure that documentation in the medical record shows that the services provided are medically necessary and reflects the severity of illness and intensity of service.
- Analyze all your denials and appeal those you think are unjustified, all the way to the administrative law judge level, if necessary.
- Follow screening criteria for patients with targeted diagnoses and make sure physicians are not overusing observation services.

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of 2012 alone, the hospital received more than 1,000 requests for records. "They ramped it up dramatically," says **Maureen Gaffney**, RPOAC, RN, senior vice president patient care services for the Long Island hospital.

One of the biggest problems hospitals face with the RAs is that the auditors can go back three years instead of looking at what hospitals are doing concurrently, points out **Pat Wilson**, RN, BSN, MBA, case management director, Medical City Dallas Hospital.

"We have made tremendous improvements in the past three years, but when it comes to the RAC audits, we're only as good as what we knew we should be doing three years ago," Wilson says.

That's why case management should be working to address the problem areas where hospitals are receiving denials and work on improving compliance now to prevent denials in the future, Berglund says. "Every day there is an unaddressed error means a day in the future when the hospital will be at risk for denials," she adds.

Hospitals should have a process in place to identify and deal with areas of risk, Berglund says. "It's hard when hospitals are dealing with 600 requests for records every 45 days. It's vital for case management to work with medical records and physicians to stop the bleed," she says.

"There's got to be a team effort around compliance. The right people need to get the information and act on it. This is an opportunity where medical records, finance, and case management can work together to stay on top of deadlines and target areas for improvement," Berglund adds.

There is an increasing need for medical records to be complete when the claim is filed, Hale says. Recovery auditors and Medicare administrative contractors (MACs) both are performing pre-payment audits that require the medical record to be submitted shortly after discharge. An incomplete record can be detrimental to the hospital's case for establishing medical necessity and DRG accuracy, she adds.

Hale cautions hospitals against improperly providing observation services to patients when they should be inpatient admissions. The Office of Inspector General's work plan for 2013 includes evaluating the over-use of observation services and how it affects patients, Hale points out.

By overusing observation, hospitals are negatively impacting their bottom line and affecting the patient financially because observation services are covered under Medicare Part B, and unless patients have a Medicare supplement plan, they have substantial co-pays for outpatient services and are responsible for the payment of medications CMS considers to be "self-administered," she adds.

When hospitals have limited resources, focusing on making sure everything is in order for conditions targeted for complex reviews will have the biggest dollar impact, Berglund says. According to the AHA, hospitals reported that 97% of all denied dollars were for complex denials, with the vast majority (84%) reporting that medical necessity was the top reason for complex denials.

Don't ignore the automated review issues, Berglund advises. According to the AHA's RACTrac, hospitals report that the top reasons for automated denials are outpatient billing error, inpatient coding error, duplicate payment, outpatient coding error and incorrect discharge status. "The denials following automated reviews represent fewer dollars than the denials from the complex reviews but they do add up, especially if extrapolation is used to apply denials across an entire collection of cases rather than individual cases. We recommend that our clients address both areas of risk," she says.

REFERENCE

1. For more information on the Centers for Medicare and Medicaid Year-End report, see: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/National-Program-Corrections-FY-2012-4th-Qtr-2012.pdf ■

Appeal, appeal, appeal those denials

The odds are in your favor

Hospitals that appeal their denials by the recovery auditors (RAs) recoup their money 75% of the time, according to data provided by the American Hospital Association. But, only 40% of denials are appealed.

Hospitals are deciding not to appeal a large number of denials, a move that is short-sighted, says **Brian Pisarsky**, RN, MHA, ACM, director in Huron Healthcare's Clinical Operations Solutions, with headquarters in Chicago. "A

high rate of denials that are appealed are overturned. By not appealing, hospitals are leaving a lot of money on the table," he says.

Hospitals shouldn't accept the RA's determination. Instead, analyze your denials individually and determine if the hospital is in the wrong. If you identify problem areas, look at ways to fix them internally. If you can justify the claim, take the time to appeal and keep appealing, he suggests.

According to the American Hospital Association, nearly two-thirds (61%)of hospitals filing an RA appeal during the second quarter of 2012 reported appealing short-stay medically unnecessary denials. On average, hospitals report appealing 118 claims through the second quarter of 2012.

It is time-consuming to appeal denials, which is why some hospitals are using third-party appeals organizations to handle their appeals even if the vendor was not involved in the initial determination of medical necessity, Pisarsky says.

Winthrop University Hospital in Mineola, NY, appeals almost every denial all the way to the administrative law judge level if necessary and is successful most of the time, says **Maureen Gaffney**, RPOAC, RN, senior vice president patient care services for the Long Island hospital.

"We have been very aggressive in how quickly we file an appeal at each level and average 60 days at all levels of appeal. It helps us stay on top of the RA appeals process and helps us recoup our reimbursement more quickly when we win the appeals," she says.

"Appeals take a long time—up to 18 months—but now we're beginning to see the fruits of our labors," she says.

Case managers must be involved in the appeals process, says **Amanda W. Berglund**, MBA, MS, partner in Pace Healthcare Consulting, LLC with headquarters in Hilton Head, SC. "Medical records can't just send the same information and expect the appeal to be successful. Case managers can provide additional information to show why the decisions were made," she says.

Hospitals need to have a way of tracking all audit activities and deadlines, Berglund points out. "An organized approach is essential if hospitals are going to stay on top of the process and appeal in a timely manner," she says. ■

Keep informed about RA focus in your area

Cardiovascular, surgical procedures are targets

The American Hospital Association reports that 88% of all hospitals responding to its RACTrac Web-based survey have received an audit under the Recovery Auditor (RA) program.

The top five medical necessity diagnoses that get denied by the RACs are coronary stents, syncope, chest pain, miscellaneous intestinal disorders, and transient ischemic attack, according to the RACTrac. Syncope and collapse and stents were the top DRGs with the most financial impact denied by the RAs, according to the survey.

"Hospitals are admitting patients with these five diagnoses and Medicare is taking back the reimbursement for a significant portion of them. The RACs are saying that these are not emergent inpatient conditions and that the services could be provided on an outpatient basis," says **Brian Pisarsky**, RN, MHA, ACM, director in Huron Healthcare's Clinical Operations Solutions, with headquarters in Chicago.

Many hospitals encourage physicians to automatically order observation services for patients who present to the emergency department with syncope or chest pain, although some patients meet criteria for an inpatient admission, says **Deborah Hale**, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, a healthcare consulting firm based in Shawnee, OK. The thinking is that because there is a preponderance of denied claims for these conditions, all patients presenting with syncope or chest pain should receive observation services, Hale says.

"If you follow screening criteria, there are high-risk patients with syncope who should be admitted," she says. Typically, patients who present with syncope are at higher risk when they have certain chronic conditions, such as valvular heart disease or cardiomyopathy, she adds.

In a significant number of cases, recovery auditors are denying reimbursement for admissions for transient ischemic attacks because the auditors determine they didn't meet inpatient criteria and their admission was not medically necessary, Pisarsky adds. To avoid denials, make sure the documentation in the medical record reflects the severity of illness and that the physician fully doc-

uments why he or she thinks the patient should be admitted in inpatient status, rather than receiving observation services, he adds.

CMS established the Comprehensive Error Rate Testing (CERT) program to monitor the accuracy of claim payments in the Medicare fee-for-service programs. The CERT Documentation Contractor randomly selects a small sample of Medicare fee-for-service claims and sends them to the provider, requesting specific documentation for the services billed. The contractor sends the documentation to the CERT Reviewer Contractor, which analyzes them for compliance with Medicare coverage, coding, and billing rules. When an error is determined, the claim is adjusted by the MAC and the money paid to the provider is taken back.

Under the CERT program, orthopedic surgical procedures, particularly hip replacement and knee replacement surgery, are coming under scrutiny for medical necessity, Pisarsky says. Many times, the documentation that shows medical necessity for the procedure is documented in the surgeon's records but not the hospital record.

"In many cases, physicians have worked with joint replacement patients, sometimes for years, and have tried pain medicine, injections, physical therapy, and other interventions but the hospital doesn't have access to this information in their electronic medical record. When a claim is denied, hospitals have to get the information from the physician's office, which can be especially difficult if the physician's electronic medical records don't interface with the hospital's," he says.

Insurance companies request information to pre-certify procedures, but hospitals have depended on physicians, he adds. Pisarksy suggests having a case manager review elective surgery cases after they are scheduled to make sure all the information to support medical necessity for the procedure before the surgery takes place. "If you do the legwork up front, it will be much easier than waiting until there's a denial," he says.

The CERTS are not only scrutinizing certain surgical procedures but also are requesting records for three-to-five day admissions when patients are transferred to a skilled nursing facility. If the patient didn't meet medical necessity for an inpatient stay for three midnights, the CERTS are denying the entire stay. In addition, the skilled nursing facility may also encounter reimbursement problems for the skilled admission.

Pisarsky suggests that case managers verify prior to the transfer that every patient being transferred to a skilled nursing facility after a three-to-five day stay meets medical necessity for at least criteria for three consecutive midnights.

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CM redesign cuts LOS, readmissions

Teams assigned to each unit

Since University Hospitals Case Medical Center in Cleveland, OH, embarked on a quality improvement initiative that included a redesign of the case management process, length of stay has dropped by almost a full day, readmissions have decreased, and the hospital's performance on 30+ metrics has increased.

The medical center received the 2012 American Hospital Association-McKesson Quest for Quality Prize in recognition of its progress and innovation in quality and patient safety.

In the new case management model, a three-person core team, each with a clearly defined role and a different focus, is assigned to each unit to work together to coordinate care and discharges. Team members include the new role of RN care

EXECUTIVE SUMMARY

University Hospitals Case Medical Center in Cleveland revamped its case management process, resulting in drops in length of stay and readmissions.

- A three-person care management team is assigned to each unit, with each member having a specific focus.
- The case management team holds rounds each day with the interdisciplinary team, which includes representatives from post-acute providers.
- An electronic board tracks patients and includes expected length of stay and discharge disposition, ancillary services, and discharge needs.

coordinator, a case manager, and a social worker, says **Catherine Koppleman**, RN, MSN, NEA-BC, chief nursing officer, University Hospitals Health System and University Hospitals Case Medical Center in Cleveland. University Hospitals Case Medical Center is the academic medical center and hub of the health system, which includes nine hospitals, 22 medical centers, and 200 primary care locations.

"We integrated case management, so it was not a parallel function but was integrated in the interdisciplinary team," she says.

On the day patients are admitted, the RN care coordinators review the medical record and determine what the patients are likely to need during the hospital stay and at discharge. They assign themselves or one other person on the core team the responsibility of coordinating those needs. "The RN care coordinator know the patients' discharge needs and assigns the patient to the right role within the core team to manage coordination and transitions to the next level of care," she says.

The case managers have a blended role of utilization nurse and clinical case manager. They review patients for medical necessity, length of stay, appropriateness of care, and clinical needs, and handle transitions of patients who are returning to an extended care facility or assisted living center. Social workers are responsible for patients in need of psychosocial counseling, those who need financial assistance, and complex patients who are being discharged to extended care facilities for the first time.

The quality initiative was developed by a large group of hospital leaders who worked to ensure a consistent model of care across all hospitals. The team designed a model of interdisciplinary, geographically based care with interdisciplinary teams assigned to each unit by service line.

It's all about differentiating roles and having people assigned to focus on a sub-population on each particular unit. "The time patients spend in the hospital is so short and the care so intense that we decided to create different roles so everyone on the team is focusing on different things. When we had a separate department of social work and a separate department of case management, the disciplines didn't necessary work together and sometimes duplicated their efforts. When everyone works together as a team, it works," Koppleman says.

The three-person core team meets every day for touch-base rounds that take about 15 minutes, during which they discuss the new patients and the plans for the day.

In addition, the entire treatment team holds daily team interdisciplinary rounds for complex patients and those who are at risk for readmission. Depending on the unit, the rounds are held at the bedside or at a conference room. The rounds are led by one of the core team, are attended by clinicians responsible for patient care, and could include physical therapy, occupational therapy, respiratory therapy, pharmacy and others depending on patient needs.

Representatives from the hospital's home care agency, and case managers from mental health facilities, post-acute facilities, and insurance companies also attend the rounds when appropriate. "Our team works closely with case managers from payers and other providers. It helps to meet people face to face when you are putting together a plan for transition," Koppleman says.

When the staff determine that patients are at risk for readmission and they don't qualify for home care, the hospital sends nurses from its home care agency into the home within 72 hours to go over the discharge plan, perform medication reconciliation, make sure the patient has a follow-up appointment with a primary care physician, and answer any questions or concerns. The readmission rate for this group of patients has decreased almost by half since the initiative began, Koppleman says.

"All studies show that if patients have contact with a healthcare professional who goes over their discharge plan within 72 hours of discharge they have less risk of readmissions," she adds.

The care coordination team tracks the patients on an electronic board that includes the expected length of stay, the probable discharge destination, what ancillary services have been ordered, and what the patient needs for discharge. When a patient is admitted, data are automatically transmitted from registration. The board is managed by the three core team members and other disciplines update the board as they complete their tasks.

The team uses an electronic transfer form, which it sends when patients are discharged to a post-acute facility. The RN care coordinator makes a follow-up phone call to make sure the receiving facility has all the information it needs.

When the hospital began focusing on readmissions in 2009, the teams on each unit received readmission data from their patients. "We gave each team their readmission rate, and the DRGs

CASE MANAGEMENT INSIDER
Case manager to case manager

Managing Length of Stay Using Patient Flow – Part 1

By Toni Cesta, PhD, RN, FAAN
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The focus on patient flow in the hospital setting began in the 1990s, when emergency department (ED) overcrowding became a serious threat to patient safety and quality of care. ED overcrowding was not limited to a geographic region or particular city. It was a widespread phenomenon that seemed to reflect greater issues in health care. Back-ups in the emergency room were reflective of issues of patient flow but also demonstrated a national problem. That problem had to do with the fact that many patients used the emergency department as their first route of entry to the health care system. There are many theories as to why this was true. It seemed to be more prevalent among the indigent and under-served who did not have rapid access to a primary care provider. Patients preferred to go to an ED where they knew they would be treated quickly. In addition, the increase in uninsured individuals also affected the numbers of patients using emergency rooms.

Combined with these issues were additional national issues:

- rising bed demand;
- limited bed / treatment capacity;
- the need to manage cost and length of stay;
- the need to improve customer service and the patient experience.

Many organizations began to take a systematic look at these issues to identify the causes, correct them, and prevent them from reoccurring.

What Is Patient Flow?

In order to apply the concepts and strategies related to patient flow, one must first understand what it really means from a practical perspective. A useful definition might be the following:

"Patient flow is a disciplined way of looking at all the patient care processes that support patients as they travel through the health care experience."

These processes occur all along the continuum of care, regardless of where care is being provided. We typically think of patient flow in terms of patient hand-offs across the continuum, and we think of it in terms of the progression of patient care within the acute care setting. The definition above allows us to think of patient flow in broad terms. Many of the care processes in which case managers work have evolved over time and haphazardly. Organizations did not always take the time to identify and correct process delays as they did not consider them in terms of length of stay, cost and quality of care as we do today. The segregation of hospital departments and disciplines maintained and sometimes fostered broken systems and processes. In some instances, ancillary departments were not aware of the effect of delays in their departments on the hospital's throughput and patient flow. For example, delays in radiology can have an effect on patient care in terms of diagnosis, treatment and discharge.

However, it was unusual for hospitals to have objective data identifying the actual time delay from when a physician ordered a test until the test was completed. Staff often knew where delays were happening, but this information was anecdotal and not quantified in any objective way. Information systems were not available to support this kind of work. For all these reasons, case managers often found themselves working around broken systems in an effort to facilitate length of stay and patient flow. It wasn't until case managers began to collect variance or avoidable delay data that hospitals began to gain a better understanding of where process delays could be improved.

Patient Flow and Quality of Care

Hospitals also began to realize that there was a dynamic relationship between bad process flow and quality of care. Patient flow issues encompassed more than just process issues affecting length of stay and cost of care. They also negatively affected the quality of care. Hospitals found that the following had strong effects on quality care:

- wrong medications or treatments including over-utilization of medications and treatments;
- misuse of product and personnel resources;
- delays in care processes, including core measures.

In addition, hospitals had to ensure that patients, as customers of the hospital, were satisfied with their care. As patients became more educated, the need to ensure that patients were satisfied customers became more and more important. As we reviewed in the last few issues of *Case Management Insider*, quality of care is tied to reimbursement. These ties go well beyond maximizing a DRG payment by controlling length of stay and resource consumption. They go right to the heart of patient care through core measures, readmissions, hospital-acquired conditions and patient satisfaction scores, among others.

Queuing Theory

Queuing theory has become part of the foundation of patient flow theory and implementation as it is applied to hospital processes. It is understood that as hospital occupancy rates increase, wait times will increase as well. In fact, as occupancy rates surpass 90%, hospital processes actually begin to slow down as more patients queue up for resources that do not increase as occupancy increases. For example, despite a high occupancy rate, the hospital retains the same number of CAT scan and MRI machines, the same amount of stress testing equipment, and so on. Therefore, more patients are lining up for the same number of resources.

Queuing theory is based on the following four premises (Jensen, Mayer, Welch & Haraden, *Leadership for Smooth Patient Flow*, Health Administration Press, 2007):

- As occupancy increases, wait time and service delays increase exponentially.
- Unscheduled or uncontrolled arrivals will behave in characteristic fashion.
- A balk is an arriving customer who sees a long line and does not seek service.
- Reneging occurs when a customer gets off a line.

Applying Queuing Theory to Hospital Processes

The elements of queuing theory are applicable to hospital care processes and reinforce commonly seen patterns that case managers deal with every day. As we just discussed, increased occupancy rates will result in delays in patient care processes. Even beyond this are expected delays that happen almost every day in our organizations. If asked what time of day your hospital experiences most of its daily delays in the emergency department, most members of your organization would answer by saying that their most common time for backups in the ED is mid-to-late afternoon. If your hospital has issues of high capacity, it is likely that your patterns happen at roughly the same time every day as patient walk-ins and ambulance traffic begin to increase.

We should also note that the PACU (post-anesthesia care unit) gets backed up on busy days around the same time as well. These patterns are predictable, but are they preventable? If one considers that they happen in characteristic or predictable fashion, then one might also consider that the ED can adjust resources and other care processes in anticipation of these patterns.

Balking will occur in hospitals when patients are aware of these common patterns of delay. We might overhear a neighbor saying, "I don't go to St. Elsewhere's emergency room because there are always long waits there. They are so disorganized and I don't want to spend my whole day there." Reneging will occur when patients come to the emergency room, but after being triaged and waiting to see the doctor for a while, may walk out without the physician seeing him or her. This can be a serious problem, as these patients may have a serious medical problem for which they need immediate treatment. This also leaves a negative impression in the community that the hospital serves.

Since most hospitals experience patterned delays, the application of queuing theory as you access your commonly experienced bottlenecks can be helpful. Emergency department delays have become a national phenomenon that became criti-

cal in the late 1990s with over half of hospitals reporting some amount of through-put delay in their EDs.

The Joint Commission and Patient Flow

Because of the national issues associated with emergency department delays, in 2005, The Joint Commission added a new standard for patient flow. The standard, LD.3.15, states "The leaders develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital."

Elements of performance for LD.3.15 include:

1. Leaders assess patient flow issues within the hospital, the impact on patient safety, and plans to mitigate that impact.
2. Planning encompasses the delivery of appropriate and adequate care to admitted patients who must be held in temporary bed locations; for example, post anesthesia care unit and emergency department areas.
3. Leaders and medical staff share accountability to develop processes that support efficient patient flow.
4. Planning includes the delivery of adequate care, treatment, and services to those patients who are placed in overflow locations, such as corridors.
5. Specific indicators are used to measure components of the patient flow process and address the following:
   a. available supply of patient bed space;
   b. efficiency of patient care, treatment, and service areas;
   c. safety of patient care, treatment, and service areas;
   d. support service processes that impact patient flow.
6. Indicator results are available to those individuals who are accountable for processes that support patient flow.
7. Indicator results are reported to leadership on a regular basis to support planning.
8. The hospital improves inefficient or unsafe processes identified by leadership as essential to the efficient movement of patients through the hospital.
9. Criteria are defined to guide decisions about initiating diversion.

Demand and Capacity Management

Demand and capacity management provide us with certain strategies for managing our organization's issues of overcrowding and processing delays from a proactive point of view. Some of these strategies include:

- identifying commonly occurring bottlenecks and delays;
- smoothing demand by identifying off-peak service opportunities;
- promoting clinically appropriate discharge times;
- sharing capacity when appropriate — real estate is a commodity;
- cross-training where appropriate.

Case managers play an important role in demand and capacity management. Later in this two-part series we will discuss case management data collection to facilitate the identification of these commonly occurring bottlenecks so they can be corrected on a go-forward basis. Once these bottlenecks have been identified, it will become important to take a look at the patterns of delay and see whether there are opportunities to extend or enhance the hours of a particular service. This may mean providing the service during extended or off-hours, or even adding staff members to provide more opportunities for providing the service.

Discharging Patients When They Are Clinically Ready

Many hospitals have set targets for discharge time. In some organizations that may be 10 am, while in others it may be 11 am. It is important that discharged patients leave the building as early in the day as possible. There is, however, another way to look at discharge times that is more consistent with demand and capacity management theories. This has to do with discharging patients when they are clinically ready for discharge, regardless of the time of day. By discharging patients throughout the day and early evening, bottlenecks can be smoothed out or avoided entirely. By spreading the admission and discharge process out over more hours, it reduces the work load in the admitting office, nursing floors and ancillary services.

Imagine how taxing it is to all the related systems in the hospital when "batching" of discharges occurs. Batching of any kind of work, such as laboratory testing, slows that process down, causing increased turn-around-time and a longer overall process. In addition, patients who leave in the late afternoon or early evening, because they are clinically ready, may appear to be "late discharges"

when in reality they are "early discharges." In less contemporary case management systems these patients would otherwise have stayed in the hospital until the next day. Today, as opportunities to reduce length of stay are less obvious, discharging patients when clinically appropriate, regardless of the time, makes sense as another source of length of stay reduction. Of course, the discharge time should not be so late in the evening that the patient may be put at risk. Common sense must always prevail.

Vacant Hospital Areas

Looking at vacant areas of the hospital during periods of overcrowding is another important technique for demand and capacity management. Some examples would include:

- Use closed or unused clinical areas during peak times.
- Consider a "holding area" for admitted patients waiting for inpatient beds, and staff this area appropriately.
- Consider a dedicated area for observation patients outside of your ED if your reimbursement schemes will support this.
- Expand the PACU space when necessary.
- Consider a discharge lounge.
- Consider the use of hall beds when necessary.

Even if you have tried one or more of these strategies in the past, you may want to consider trying them again. As the healthcare system continues to evolve, and as dollars continue to be tight, circling back to methods of the past with renewed interest can sometimes be helpful. Holding area, discharge lounges, and dedicated observation areas are all examples of strategies that have been around for a while and that you may have tried and abandoned at some point. Try them again. They may just work this time!

When patient flow is well-managed, outcomes can be improved in three ways:

1. improved patient safety;
2. improved quality of care;
3. improved operational efficiency.

When patients receive the clinical care they need in a timely fashion, this reduces the likelihood of a treatment delay that can result in a poor outcomes for the patient. Patients are not exposed to the acute care environment for any longer than they need to be, thereby reducing their exposure to errors, infections or falls. By improving care processes and reducing delays in service, the quality of care to the patients is improved. Patients are treated when clinically necessary and without long delays; this is fundamental to achieving quality of care and improving patient safety.

Finally, operational efficiency, including service delivery turn-around-times, is enhanced, having a positive effect on the bottom line of the hospital. Clearly, when the hospital positively impacts on cost, it also positively impacts on quality of care. These issues are entwined and directly relate to each other. This is why case managers are so integral to the patient flow process. They are the staff that provide the balance and the link between the clinical and financial worlds.

Summary

This month we have discussed the fundamentals of patient flow and its related theories. We reviewed the concepts of demand and capacity management as they apply to the hospital setting. Patient flow requires daily diligence and attention. It should not be something focused on only on busy days, but should be managed each and every day. By taking a proactive approach to patient flow, the number of days your hospital will be bottlenecked can be reduced. Patient flow needs to be part of the daily activities of every case management department and should be factored in as a core role and function in a contemporary case management department. Patient flow needs to be addressed at the patient, departmental, and hospital level.

In next month's issue we will continue our discussion on patient flow with a detailed review of specific examples that any case management department can use. We will also review all the departments and disciplines that contribute to patient flow and their role in it. ■

being readmitted and assigned them to look at the root causes for readmission and come up with ways to reduce them," she says. Now, when patients are readmitted, the core care coordination team rounds on the day of admission, reviews the cause of the readmission and uses the information to put together a better discharge plan.

The hospital has partnered with extended care facilities and other agencies in the community on readmission reduction efforts. A dialysis center has a care coordinator who follows patients across the continuum and who comes into the hospital to work with dialysis patients and develop a discharge plan with the hospital team. The hospital has made its inpatient medical records available to the dialysis care coordinator to aid in the transitions. The Western Reserve Agency on the Aging has trained coaches on using the Care Transitions Intervention, developed at the University of Colorado, to facilitate transitions. The coaches are being integrated into the hospital's interdisciplinary rounds when the patients are elderly.

"We are focusing more on the continuum of care and creating smoother transitions. By working with other providers and agencies in the community, we can improve patient care and keep people out of the hospital and the emergency department," she says. ■

Team huddles improve LOS, core measures

All units follow same procedures

After Springfield Regional Medical Center in Springfield, OH, began daily multidisciplinary team huddles to facilitate patient care, the hospital's performance on targeted core measures rose to the 95th quartile compared to a range of 75% to 81% when the project began, and the housewide ratio of the observed-to-expected length of stay decreased from 1.15 to 1.07.

"Our goal with this project was to bring consistency to each unit throughout the hospital, increase our adherence to core measures, and create the best quality care for all patients. We knew that Medicare's value-based purchasing program was coming, and we wanted to be well positioned to succeed. The units all had different processes and we saw a lot of opportunities to standardize processes throughout the hospital," says **Holly McGowen**, RN, BSN, performance improvement nurse coordinator for quality and case management for the 284-bed hospital.

The process was designed by a committee that included the unit directors, unit managers, charge nurses and case managers on the unit as well as representatives of every ancillary department. They met to discuss what happens with patients from their perspective from admission to discharge, what responsibilities they have for ensuring core measures compliance, and what needs to happen for the patients to move through the continuum as efficiently and safely as possible.

The team targeted core measures for acute myocardial infarction, heart failure, pneumonia, and the surgical care improvement measures and looked at ways to ensure that patients get the care they need in a timely manner.

The hospital began with a pilot project on the 23-bed step-down unit, which generally had a high length of stay and a lot of opportunities each month for improvement on core measure compliance.

A key part of the process was implementing daily multidisciplinary team huddles, facilitated by the case manager and the charge nurse, during which every member reviews every patient. *(For details on how the team huddles work, see related article on page 24.)* "It takes a whole team working together to provide good patient care. During the huddle, the team works together to develop care plans, follow-up on care plans, and improve patient flow through the system by addressing patients' needs in a timely and

EXECUTIVE SUMMARY

When Springfield (OH) Regional Medical Center began daily multidisciplinary team huddles to facilitate patient care, performance on targeted core measures rose and the observed-to-expected length of stay ratio decreased.

- Case managers and charge nurses on each unit facilitate the daily multidisciplinary huddles during which every patient is discussed.
- The team uses a series of tools, including huddle logs and referral sheets to track what patients need and who should provide the services.
- At the huddles, which are at specific times every day, the team reviews each patient, the plan of care and goals, and what needs to happen that day.

precise fashion," says **Susan Molloer**, RN, manager of quality and case management.

The director or manager in each ancillary department selected one colleague to represent the department at the daily huddle. The departments can include case management, nursing, nutrition, palliative care, pharmacy physical therapy, occupational therapy, quality, respiratory services, wound care, and spiritual care.

The charge nurse and the case manager always attend the huddle on their unit. Ancillary services participate where they are most needed. For instance, physical therapy is always represented at rounds on the surgical unit. Respiratory services always has a representative when the team rounds on patients in the intensive care unit or step-down unit who are on ventilators or who have breathing problems. A hospice liaison is available for medical oncology rounds.

"We try to utilize the ancillary departments' expertise and have them participate in patient huddles where they are most needed," McGowen says.

When the pilot project began, the team on the step-down unit developed a series of tools to help facilitate the improvement process and make sure that nothing falls through the cracks. These include a huddle sheet with boxes for diagnosis, admission date, place of residency before admission, and applicable core measures. The huddle sheet is updated daily. Other tools include a referral sheet with spaces for referrals for each discipline, and a huddle log that summarizes core measures components.

The team created color-coded core measure order sets (orange for acute myocardial infarction; green for heart failure, pink for pneumonia, and blue for surgical care improvement project measures). The unit created colorful educational bulletin boards in a "Core Measures Corner" featuring reference tools for nurses to remind them to ensure core measures compliance. The unit selected core measures champions for each measure and implemented monthly core measures meetings during which the champions educate the staff on changes in the core measures as well as performance on the unit.

During the first 60 days, the length of stay decreased by 20% and the number of opportunities for improvement on core measures compliance dropped from seven to three.

After the pilot in April 2010, the process and all the components of the pilot project were rolled out across every unit in the hospital by August 2010.

"We're taking a proactive approach to patient care and look at the patient's progress and the needs of the day every morning. Quality and case management are working together to drill down on readmissions and opportunities for improvement in the discharge process," Molloer says. ■

Short huddles focus on plan of care

Average time: 17 minutes

The multidisciplinary team on each unit at Springfield Regional Medical Center in Springfield, OH, holds short team huddles at a specific time every day and reviews each patient, the plan of care and goals, and what needs to happen each day.

The huddles are held in the unit conference room and take an average of 17 minutes, during which time the team looks at 24 to 30 patients. Case managers and charge nurses always attend the huddles. Ancillary departments attend the meetings on units where their expertise is most needed, according to **Holly McGowen**, RN, BSN, performance improvement nurse coordinator for quality and case management for the 284-bed hospital.

Each morning, the unit secretary prints a patient census for the charge nurse, who fills out a multidisciplinary huddle sheet for each patient.

To begin the meeting, the charge nurse or the case manager on the unit reviews the patient demographics and what treatment has been completed or is pending for the patient, and what the expectations are for the day. Each participant on the team makes recommendations for their department. If the team anticipates orders for the day, the department responsible for carrying out the orders is notified. For instance, if there is expected to be an order for the patient to go from IV antibiotics to oral antibiotics, pharmacy is alerted that the order

is coming so that it can have the proper medication ready.

For instance, the nutrition department may make a dietary recommendation for a patient with heart failure. The nurse or case manager may notice that a post-operative patient could benefit from a physical therapy consultation. The charge nurse updates the sheet after each meeting, adding what care is decided on, what has been implemented, and what needs follow up. If the patient is transferred to another unit, the sheet goes with him so the receiving unit can use the plan of care already developed and modify it to meet patient needs.

"We want to make sure the patients get the best care as early as possible. Our goal is to see where the patient is right now and what we need to do for the patient to progress through the continuum of care," McGowen says. ■

Study links HCAHPS, readmission rates

High performers have fewer readmissions

If your hospital receives high scores on the Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS), 30-day readmission rates are likely to be low, according to a study by Press Ganey, a South Bend, IN, health care performance improvement organization.

Press Ganey analyzed hospitals' readmission penalty data and compared it to their performance on the Centers for Medicare & Medicaid Services (CMS) value-based purchasing measures. The study found a strong correlation between 30-day readmissions and performance on the HCAHPS portion of the Value-Based Purchasing Program. Performance on the clinical measures included in value-based purchasing was not linked to readmissions rates.

Good communication with patients and family members is a major factor in performance on patient perception of care measures as well as on the hospital's success in preventing 30-day readmissions, points out **Nell Buhlman**, vice president for product strategy for Press Ganey.

The HCAHPS survey asks patients to rate communication with nurses and physicians, responsiveness of the hospital staff, and discharge information, along with questions about cleanliness and quietness of the hospital environment, and pain management. Many of the questions focus on communication and the hospital's effectiveness in engaging patients — factors that also affect patients' ability to care for themselves after discharge and avoid being readmitted, she adds.

"Developing a good foundation for patient-centric care and focusing on patient and caregiver communication are an excellent step toward improving a hospital's performance on the HCAHPS and success in preventing readmissions," she adds.

The message for case managers is that they should start discharge planning on admission and communicate frequently with patients and family members during the stay, Buhlman says.

Many hospital readmissions occur because patients don't follow their discharge instructions, fail to take their medication correctly, and don't have the community resources they need to manage after discharge, all of which indicate gaps in communication, Buhlman says.

"If patients understand their discharge plan and have lots of opportunities to ask questions, they are more likely to be compliant with their medication regimen and discharge instructions," she points out. At the same time, if case managers take the time to find out about patients' support systems, home environment, psychosocial needs, and any barriers to receiving care in the community, the discharge plan is more likely to be effective, she adds.

Inform patients about their expected length of stay from the beginning and repeat the conversation every day of the stay, she advises. "When patients are in the hospital and on medication, they experience anxiety and stress and may not remember something they hear only once. Case managers should renew the conversation about their discharge date and discharge plan every day and give patients a chance to ask questions," she says.

She also advises establishing partnerships with post-acute providers to facilitate transitions in care. "Healthcare performance measures are moving beyond the traditional spheres of responsibility. Providers throughout the continuum should work together to make sure transitions are smooth and that they are providing information to care for patients at the next level of care," she says. ■

Safe lifting becomes standard practice

ANA draft standards for employers, HCWs

Safe patient handling should be standard practice, not best practice. That is the message behind new, draft standards issued by the American Nurses Association (ANA).

The ANA hopes to spur new action at health care facilities around the country while providing a basis for federal action on a safe patient handling law, says **Suzy Harrington**, DNP, RN, MCHES, director of the Department for Health, Safety and Wellness for the ANA, which is based in Silver Spring, MD. Final standards are expected in late 2013.

"The intent is to make them the standards of care. We want them to be realistic and attainable while raising the bar," Harrington says.

A working group of leading safe patient handling experts crafted the standards with expectations for both health care employers and employees. They call for health care employers to create a "culture of safety," a safe patient handling program with appropriate equipment and training, patient assessments and accommodations for injured employees. *(See box on right.)*

The standards provide an important framework for hospitals, says **Mary Bliss**, RN COHN, coordinator of Employee Health Services at Methodist Medical Center in Peoria, IL, and the working group representative from the Association of Occupational Health Professionals in Healthcare (AOHP).

While 10 states have laws requiring a safe patient handling program, and the Veterans Health Administration has guidelines, the ANA standards create a set of expectations. "[With the standards,] there's no question about what needs to be done to protect workers when they're moving patients," she says.

"It will define some of the essential ingredients [for safe patient handling]," while allowing facilities flexibility to find solutions that work for them, says **Guy Fragala**, PhD, PE, CSP, CSPHP, senior adviser for ergonomics at the Patient Safety Center of Inquiry at the James A. Haley Veterans Hospital in Tampa, FL, a member of the working group.

The backdrop for these draft standards is somewhat bleak. Health care remains one of the nation's most hazardous industries with the highest levels of MSD injuries despite 10 state laws and years of research showing the benefits of safe patient handling.

Nursing assistants had a higher number of work-related musculoskeletal disorders (MSDs) than any other occupation in 2011, according to the U.S. Bureau of Labor Statistics. In a 2011 ANA survey, about 80% of registered nurses said they worked with musculoskeletal pain and 62% cited a disabling musculoskeletal injury as one of their top health and safety concerns.

Patients with impaired mobility are also at risk of falls and skin ulcers. Safe patient handling advocates are increasingly pointing to the link to patient safety. "Nurses are still getting injured, patients are still getting injured," says Harrington. "Something needs to be done. This really needs to be moved to the next level."

The ANA standards are voluntary. But ANA

Setting a new SPH standard

The American Nurses Association recently released a draft version of safe patient handling standards, including elements of performance. The ANA's eight core standards are listed below:

1: Create a Culture of Safety
2: Implement and Sustain a SPHM Program
3: Incorporate Prevention through Design Providing a Safe Environment of Care
4: Select, Install, and Maintain SPHM Technology
5: Establish a System for Education, Training and Competency
6: Incorporate Health Care Recipient Centered Assessment, Care Planning, and Use of Technology
7: Include SPHM in Reasonable Accommodation and Post Injury Return to Work
8: Establish a Comprehensive Evaluation Program

The ANA draft standards are available at: www.nursingworld.org/MainMenuCategories/WorkplaceSafety/SafePatient ■

hopes to promote change through collaboration with the U.S. Occupational Safety and Health Administration and the National Institute for Occupational Safety and Health.

"We need to move [safe patient handling to the place] where personal protective equipment has moved, where it's not optional, it's required. It's just a part of doing business," Harrington says.

The standards set the expectation for health care workers, as well. "We know sometimes there's resistance to change among nurses," says Fragala. "We're trying to change practice, going from manual lifting to safe lifting. I think this is going to empower [employees] to change practice and accept that equipment is the way to do this."

The standards begin in the broadest context with a "culture of safety." Employers are expected to create a blame-free environment that encourages reporting of incidents, provide adequate levels of staffing, and promote safety as a corporate value.

Employees are expected to actively participate in safety measures and promptly report hazards, incidents and accidents. Employees also have the right to refuse or object to an assignment that puts them in danger, the draft standards say.

The culture is ultimately set by the hospital's top leadership, Bliss says. "No program within a facility is going to be successful unless the top executive leadership is supportive," she says. "They have to have a commitment to it and an expectation."

The standards also prompt the development of a safe patient handling and movement program with broad language that allows employers to determine the specific policies or mix of equipment. They call for written policies with goals and objectives, sustainable funding, integration throughout the organization, and communication about its importance.

Training is a standard in itself, as is the incorporation of safe patient handling into building design. To help hospitals implement the standards, the ANA plans to follow up with additional resources and a re-launch of the Handle With Care program,

CNE OBJECTIVES

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

- identify the particular clinical, administrative or regulatory issues related to the profession of case management
- describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the 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

■ Ways to avoid emergency department boarding.

■ Discharge planning for the uninsured.

■ Readmission reduction strategies that work.

■ Recruiting and retaining CM staff.

CNE Questions

1. When observation services are ordered, patients who do not have a Medicare supplement plan have substantial co-pays and also must pay for what CMS considers "self-administered" drugs.
   A. True
   B. False

2. According to the American Hospital Association, what percentage of denials by the Recovery Auditors (RAs) are overturned upon appeal?
   A. 40%
   B. 50%
   C. 75%
   D. 90%

3. According to Brian Pisarsky, RN, MHA, ACM, director in Huron Healthcare's Clinical Operations Solutions, what are the major medical necessity targets of the Medicare Comprehensive Error Rate Testing (CERT) documentation contractors?
   A. Orthopedic surgery and three-to-five day stays when patients are transferred to a skilled nursing facility.
   B. Hip replacement surgery and knee replacement surgery.
   C. Syncope and chest pain.
   D. Miscellaneous intestinal disorders and transient ischemic attack.

The multidisciplinary team on each unit at Springfield Regional Medical Center in Springfield, OH, holds daily huddles during which they discuss between 24 and 30 patients. How long does the average huddle last?
   A. 10 minutes.
   B. 17 minutes.
   C. 15 minutes.
   D. 21 minutes.

says Harrington.

"People [often] think they have a safe patient handling program, but it's not really comprehensive," she says. "We wanted to address all the different components that are really vital for a true safe patient handling program."

Ultimately, safe patient handling becomes an integral part of patient care, says Bliss. At Methodist Medical Center, for example, communication about the program reaches patients, workers, managers, and even the board of directors.

When patients are admitted, they receive a brochure that shows patient handling equipment and how it is used. Mobility assessment is an integral part of the daily patient assessment.

Meanwhile, the CEO showed her support for safe patient handling by testing out the equipment herself. And following Illinois law, the hospital has a multidisciplinary safe patient handling committee and reports patient handling injuries to the hospital's Patient Steering Committee (an environment of care committee) and the board of directors.

There has been good news to report. In 2005, before implementing the program in May 2007, the hospital had 40 OSHA-recordable patient handling incidents that led to more than 2,000 restricted work days and up to 288 lost-time days. In 2011, there were only two incidents and there have been three consecutive years of no lost-time days.

"You have to keep monitoring [the program], working through issues and making it better," says Bliss. "It is time consuming, but it is well worth it." ■

CNE INSTRUCTIONS

Nurses participate in this continuing education program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■