HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

May 2013: Vol. 21, No. 5
Pages 57-72

IN THIS ISSUE

Financial Disclosure:
Executive Editor **Russ Underwood**, Associate Managing Editor **Jill Drachenberg**, Editor **Mary Booth Thomas**, and Nurse Planner **Toni Cesta**, PhD, RN, FAAN, Consulting Editor of *Hospital Case Management*, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

Focus on value-based purchasing to help your hospital succeed

Discharges, transitions play a big role

As the Centers for Medicare & Medicaid Services' (CMS) Value-Based Purchasing program moves toward basing reimbursement on quality, case managers can take the lead in making sure their hospitals score well and don't lose reimbursement.

"Case managers can influence many of the targets in value-based purchasing, and they have the advantage of being the consistent component of the care team while other team members may see patients intermittently. Case managers play a big role in discharge planning and transitions of care, which ties into a lot of areas in value-based purchasing, particularly Medicare spending per beneficiary," says **Danielle Lloyd**, MPH, vice president, policy development and analysis for the Premier healthcare alliance.

Beginning with discharges on Oct. 1, 2012, CMS is penalizing and rewarding hospitals based on a complicated formula that determines how well they perform in two domains: 12 measures of clinical processes of care and eight patient experience measures from the Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS). For fiscal 2013, hospitals automatically lose 1%

EXECUTIVE SUMMARY

Case managers are in a position to help their hospitals score well and not lose reimbursement as the Centers for Medicare & Medicaid Services shifts from paying hospitals for quantity and moves toward basing reimbursement on quality.

- Be aware of the metrics included in value-based purchasing, analyze your metrics, and make improvements.
- Make the case for technology to help case managers analyze all the data needed to identify areas for improvement.
- Keep in mind that CMS is adding new components every year and that the measurement period starts long before the payment year.

of their Medicare base operating payment for each discharge. Hospitals that performed well on the value-based purchasing metrics compared to other hospitals and/or improve their performance on the measures receive value-based incentive payments.

Hospital Case Management™ (ISSN# 1087-0652), including Critical Path Network™, is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Website: www.ahcmedia.com. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Case Management™, P.O. Box 105109, Atlanta, GA 30348.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 Mon.-Thurs.; 8:30-4:30 Fri. EST. E-mail: customerservice@ahcmedia.com. Web site: www.ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $78 each. (GST registration number R128870672.)

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 18 clock hours.

The target audience for Hospital Case Management™ is hospital-based case managers. This activity is valid 24 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Mary Booth Thomas**, (marybootht@aol.com).
Associate Managing Editor: **Jill Drachenberg**
Executive Editor: **Russ Underwood** (404) 262-5521 (russ.underwood@ahcmedia.com).
Production Editor: **Kristen Ramsey.**
Senior Vice President/Group Publisher: **Donald R. Johnston.**

AHC Media

Editorial Questions
For questions or comments, call Russ Underwood at (404) 262-5521.

The worst performers are losing almost the full 1% of their base operating payment while the top hospitals are earning the 1% reduction back and getting a bonus of a little less than 1%, Lloyd says.

"This is a budget-neutral system with a cap on how much an organization can lose but not a cap on how big bonuses will be. What hospitals can earn is dependent on the performance of other hospitals, as well as their own performance," she says.

Hospitals with a lot of Medicare patients have a growing and significant amount of reimbursement at stake, based on the quality of their outcomes, Lloyd points out. Premier is monitoring the value-based purchasing program to ensure that no particular type of hospital is disproportionately impacted, Lloyd says. "Right now, based on our modeling, urban teaching hospitals that serve a disproportionately high number of low-income patients tend to have poorer performances," she says.

All case managers need to be aware of the metrics included in value-based purchasing, says **Beverly Cunningham**, RN, MS, vice president of resource management at Medical City Dallas Hospital. Cunningham's hospital received a bonus in the value-based purchasing program. *(For a look at hospitals that did well under the program, see pages 60-63.)*

"While we want all our metrics to be great, we should really key in on those in value-based purchasing because they affect the reimbursement the hospital gets," she says.

To succeed, hospitals should have strong initiatives in three key areas: core measures, HCAHPS, and readmissions, Cunningham says. "If hospitals don't have those three area of focus hard-wired into the culture, they're behind the eight ball," she says.

Hospitals need to know their individual results in each category and be able to identify trends so they can make improvements, Cunningham says. In her state, the Texas Hospital Association sends out a detailed quarterly report that includes a trend estimate for value-based purchasing, she says. The association contracts with a company that aggregates data for each hospital, she adds.

The report includes the score for the key areas in value-based purchasing and estimates the impact for the future. Cunningham suggests that case management directors check with their

chief financial officers to determine if there is similar data available in their states.

Investing in technology

To succeed under value-based purchasing, it is essential for hospitals to standardize their processes of care throughout the patient stay, including patient education, discharge planning, and follow-up, and to analyze data to determine where improvements can be made, says **Karoline Hilu**, MD, a principal for strategic planning at The Advisory Board Company, a healthcare technology, research, and consulting firm based in Washington, DC.

The first step in the improvement process is investing in technology that you can use to identify opportunities for improvement so your staff can determine where to focus. "Those institutions that invest in technology and determine which patients are at highest risk are in the best position to succeed in value-based purchasing," she says.

"The number of measures included in value-based purchasing and other programs adds to the amount of manual work the staff has to do. Hospitals need to invest in technology that can guide staff in determining what to do for each patient at the right time," Hilu says.

For instance, predictive modeling software eliminates the need for manual chart review by automatically identifying that a patient has been admitted and is at high risk for readmission, Hilu says. "Then the technology can guide the care managers in specific interventions during the inpatient stay, as well as a safe and appropriate transition to the next level of care," she says.

Case managers should be heavily involved in identifying patients who are readmitted and determining the reason for the readmission in order to aggregate the data and look for trends, Cunningham says. In addition, be aware that incidences of readmissions and mortality count against the discharging hospital, regardless of where they occur and take steps to identify patients who are admitted to other hospitals whenever possible, she adds.

Having an electronic case management system for collecting information is critical for hospitals to be able to aggregate data, Cunningham says. "Hospitals can no longer afford for case managers to jot down information on pieces of paper and tally it. Case management directors have got to go to bat for getting an electronic system of some sort where they can input data and run reports," she says.

HCAHPS scores had a big impact on hospitals' value-based purchasing scores in 2013, Lloyd says. "The process measures have been around for a while and many of them are close to being topped out. There's a lot of high performance and not much room for hospitals to improve," she says.

A lot of organizations are looking at HCAHPS data to determine areas where the scores are lowest and developing process improvement projects, Lloyd says. Some hospitals have developed patient advisory councils to give them suggestions on how to improve the patient experience, she adds.

Improving scores on the HCAHPS is not easy, Lloyd adds. "We also have concerns that we have expressed to CMS that the risk adjustment is not adequate on the patient experience scores. Hospitals that care for more acutely ill patients tend to have lower patient experience scores," she says.

Unlike readmissions data, core measures, and other metrics, patient satisfaction data show only aggregate scores. "A hospital's final score doesn't identify who the patients are who gave bad ratings, and since the survey is completed after discharge, there's no way to drill down three months later and deduce what happened in a specific incidence," adds **Hiten Patel**, managing director, research and insight, at The Advisory Board Company.

Instead, he suggests that hospitals focus on areas where they don't score well, examine the processes that are in place, and take steps to make changes.

"Some institutions are beginning to collect information included in the HCAHPS survey in real time, during the patient stay. In the future, hospitals are going to have to develop ways to predict outcomes scores while the patient is still in the bed and determine how to improve, in order to move the dial," he says.

SOURCES

- Beverly Cunningham, RN, MS, Vice President of Resource Management at Medical City Dallas Hospital. email: Beverly.Cunningham@hcahealthcare.com
- Karoline Hilu, MD, a Principal for Strategic Planning, The Advisory Board Company, Washington, DC. email: HiluK@advisory.com.
- Danielle Lloyd, MPH, Vice President for Policy Development and Analysis for the Premier healthcare alliance, Charlotte, NC. email: Danielle_Lloyd@PremierInc.com ■

Stay ahead of the curve to succeed under VBP

New measures to be added in the future

When it comes to doing well on the Centers for Medicare & Medicaid Services' (CMS) Value-Based Purchasing Program, hospitals need to "take care of today but also take care of tomorrow," says **Beverly Cunningham**, RN, MS, vice president of resource management at Medical City Dallas Hospital.

Don't be lulled into a false sense of security if your readmissions or other data look great today, because it's just a sample, Cunningham warns. "Every time CMS collects more data, they use a different group of patients," she points out.

"This program is just getting started, and with each passing year, new domains and new measures will be added. Hospitals may do well in one year and not as well in the next because of different measures and different performance by other hospitals," adds **Danielle Lloyd**, MPH, vice president, policy development and analysis for the Premier healthcare alliance.

Keep in mind that the measurement period for value-based purchasing is well in advance of the payment period. "Hospitals can't wait until the payment years to take steps to improve their quality. They need to watch what is coming into the inpatient quality reporting program and assume that those measures are on deck for value-based purchasing," Lloyd says.

Only processes of care and patient experience domains are included in value-based purchasing for fiscal 2013, but the program will evolve over the next few years as new elements are added and some measures are removed, says **Hiten Patel**, managing director, research and insight, at The Advisory Board Company, a healthcare technology, research and consulting firm based in Washington, DC.

The percentage of hospitals' base operating payment affected by value-based purchasing will grow in the future, by one-fourth of 1% per year until it caps out at 2%. Value-based purchasing measures for fiscal 2013 include 12 clinical processes of care, which are basic core measures, and eight patient experience measures from the Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS). In fiscal 2013, 70% of a hospital's score is based on the clinical processes of care and the remaining 30% on performance on the HCAHPS, Patel says.

In fiscal 2014, beginning Oct. 1, 2013, CMS is adding three outcomes measures — 30-day all-cause mortality for heart failure, pneumonia, and acute myocardial infarction — and retaining the original two domains: clinical processes and patient experience. In fiscal 2015, central line-associated bloodstream infections and the AHRQ patient safety indicators will be added to the outcomes domain. Also in 2015, an efficiency domain, including Medicare spending per beneficiary, will be added, making four domains — clinical processes of care, patients experience of care, outcomes (which includes mortality and patient safety), and efficiency.

Medicare spending per beneficiary is a compilation of Medicare Parts A and B payments from three days prior to an admission through 30 days after discharge. "CMS is trying to get hospitals to think about how they can influence overall spending once patients are outside their four walls. This is where case managers can have a big influence on their hospitals' scores by determining the best post-discharge plan for each patient and making sure the transition goes smoothly," Lloyd says.

Know what is coming down the pike and get ready for it, Cunningham suggests. "We know that there has been discussion about a length-of-stay metric, and CMS has indicated that it will include more DRGs in the data for readmissions and mortality. Case managers should be familiar with the Inpatient Prospective Payment System proposed rules that come out in the spring and be aware that they can comment on what CMS proposes," she says. Then watch for the final rule in August that will take effect October 1, she adds. ■

Hospital earns biggest bonus under VBP

Staff focus on quality, the patient experience

At Treasure Valley Hospital in Boise, ID, recipient of the biggest bonus under the Value-Based Purchasing Program, the entire team focuses on clinical quality and the patient experience, says **Nicholas Genna**, chief executive

officer of the 10-bed physician-owned surgical hospital.

"Clearly, clinical quality comes first. We go over and over that with every teammate. But we also work hard on the overall patient experience," he adds.

The hospital pays close attention to how its scores on Hospital Compare measure up to scores of local competitors, state, and national statistics and looks for opportunities to make improvements, adds **Charon Castanon**, MS, RN, director of quality. "We are attuned to producing the best possible clinical outcomes and patient experience," she says.

The hospital has a 3-to-1 patient-to-nurse ratio. The admissions staff and the operating room staff attend patient rounds, and the hospital leaders take turns rounding. "We all want to see firsthand how the patients are doing and what their experiences are," Genna says.

After discharge, every patient receives a thank-you note that is signed by everyone who provided care during the hospital stay.

At Treasure Valley Hospital, the inpatient nurse manager also acts as a case manager and is responsible for utilization review. Discharge planning is handled by all the nurses, with the nurse manager having ultimate responsibility. "All of our nurses are trained in care coordination," Genna says.

The nurse assesses patients before the surgery, either when the patient comes in for preadmission testing or on the telephone to make sure they meet admissions criteria, determine what their needs will be after discharge and to make sure they have resources in place at home for a safe discharge. They educate the patients about the surgical process, their hospital stay, and pain management alternatives.

Post-acute care

The nurse manager reviews the patient's chart on Day 1 and works with the nurses on the floor to anticipate their needs. For instance, if the patient has had spinal surgery, she makes sure that physical therapy is ordered. If the patient will go home with new medications, she calls in the pharmacist to review all the medications.

When patients are discharged, the nurse works with the post-acute services to ensure that they have all the information they need and makes follow-up calls to make sure patients are not having problems. "We follow patients through the continuum of care to make sure they have a successful discharge and are not readmitted," she says.

Recognizing that pain management may be an issue for surgical patients, the nurses make sure the patient's pain is under control before he or she leaves the hospital.

The staff use checklists as a reminder of the Surgical Care Improvement Program (SCIP) measures and other measures that should be in place. In addition, the electronic medical record includes prompts as reminders of the guidelines. "We have worked to ensure that there are checks and balances so nothing is missed. Our preoperative list includes all patient safety measures as well as the SCIP measures," Castanon says. ■

After bonus, hospital continues to focus on VBP

Staff looks ahead to potential new metrics

Medical City Dallas Hospital earned a bonus from the Centers for Medicare & Medicaid Services' (CMS) Value-Based Purchasing Program, but the 530-bed medical and surgical hospital isn't resting on its laurels.

"We're not sitting back and thinking we've got it made. This is an ongoing process that will not stop. We are staying informed about the new metrics that CMS is adding to value-based purchasing and concentrating on all of the components of the program," says **Beverly Cunningham**, RN, MS, vice president of resource management.

The hospital has delegated responsibility for leading initiatives on the various components of value-based purchasing to hospital leaders. The chief nursing officer is the champion of Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) measures. The vice president of quality is champion for core measures. Cunningham and the chief nursing officers are champions of readmissions, with the director of case management and a nurse manager taking a leading role.

Every department in the hospital that is involved in patient care gets a weekly report

on core measures and the HCAHPS scores. In addition, the hospital posts dashboards on each unit with that unit's scores. "Everybody on the unit knows the trends and how they compare to other units," she says.

The leadership team drills down on every core measure outlier score and sends an abstract to the quality improvement coordinator responsible for that core measure and the nurse manager on the unit where the outlier occurred. The nurse manager interviews the nurse responsible for that core measure outlier to understand what happened, what can be improved, and how to spread the word to other staff. "The leadership wants to understand what happened so as leaders, we can remove any roadblocks the nurses have," she says.

The chief nursing officer holds an outlier meeting twice a month attended by the nurse manager from any unit that had an outlier, the nurse responsible, and representatives from quality and nursing. "It's not a punitive meeting. We discuss what happened, how to improve, and how to share the information with the rest of the staff. Everybody goes back to their nursing unit and tells three people, who tell three people, and so on, to spread the word," Cunningham says.

Drilling down on readmissions

Each unit picks two HCAHPS measures and focuses on making improvement for two months, then re-evaluates. "Patients fill out the HCAHPS survey after discharge and we don't know what patient gave us what score. It's very different from core measures when we know the exact outlier and who is responsible. We get data every week and we can't look at every data piece," she says.

The hospital's readmission team is aggregating data about readmissions and drilling down on each readmission to find out the cause. The electronic case management system automatically flags patients when they come back to the hospital within 30 days after discharge. The case manager alerts the unit nurses that a patient has been readmitted. "The admitting nurses wouldn't know that the patient was being readmitted, but the electronic system allows immediate identification. This is one of the compelling reasons for having an electronic case management system," Cunningham says. ■

Patient-centered care helps hospital succeed

Families are part of whole experience

When Patewood Memorial Hospital in Greenville, SC, opened six years ago, the hospital administration recognized an opportunity to provide care that was centered around the patients and family members' experiences, or patient-centered care, says **Beverly Haines**, MNEd, BRN, NE-BC, president of the 72-bed surgical hospital, which is part of the Greenville Health System. The hospital earned a bonus under the Centers for Medicare & Medicaid Services' Value-Based Purchasing Program.

"We concentrate on making sure our patients and family members are part of the whole experience. We have a very strong interdisciplinary staff who work closely together. All of the clinical services report to me so people don't have to go up the chain to get anything done. We all talk to each other," she says.

Before the hospital opened, the staff sat down and talked about how to make the surgical process focused on the patient and family, Haines says. "Most of the staff was accustomed to the traditional model of care and there was some push-back, but we worked through the objections and now everything is done around what patients want to experience when they are in the hospital," she says.

For instance, the anesthesiologists and the certified nurse anesthetists were reluctant at first to have family members come into the recovery room once the patient is settled in after surgery. Now the hospital encourages two family members to sit with the patient. "It reduces the anxiety for the family as well as the patient, and they love it," she says.

The majority of patients are admitted for orthopedic and spine surgery. Patients who are scheduled for joint replacement surgery and their families attend a comprehensive joint day, three weeks before the surgery, to learn up-front what to expect during and after surgery says **Susan Ballew**, RN, BSN, nurse manager on the orthopedics unit. A multidisciplinary team, including physicians, presents a class to prepare patients for the surgical experience.

"The moment patients enter the building for surgery, they know what to expect, beginning with

pre-op, the operating room, the recovery room, and the nursing unit. It helps to allay their fears and help them feel more comfortable about the surgical procedure," Ballew says.

During their preoperative visit, patients are pre-assessed by nursing and anesthesiology, and meet with a hospitalist who may make referrals, such as to a cardiologist, if further assessment is needed. Patient education classes are taught by nursing, and a physical therapist who teaches them exercises that can help them recuperate from surgery faster and have a shorter length of stay.

They meet with the case manager, who completes an assessment to determine patients' post-operative support system, their home situation, and their discharge needs. The case manager educates the patient and family members about the anticipated length of stay and what they need to do to prepare for discharge. The case manager has the patient name a "care partner" who will participate in the discharge education and care for the patient after discharge. Care partners are identified by name and given a badge that alerts the staff as to who they are and allows them to visit at any time.

Those who walk into the hospital are escorted to their destination by a volunteer or a staff member who tells them his or her name, credentials, and role. "We set the bar high and have kept it there," Haines says.

Instead of the traditional dietary menu, the hospital offers a liberalized upscale menu created by a chef. "Patients who have diabetes and other conditions know what they should eat, and we're not going to be able to change their eating habits during a short stay. We let them choose from appealing and nutritious foods," Haines says.

A panel of discharged patients and their families serve as Patewood Healthcare Partners and advise the staff on various projects. Their input was used when the hospital participated in an AHRQ project to develop a patient and family engagement guide and in the hospital's initiative to change the shift report to the patients' bedsides. Patewood is one of only four hospitals nationwide that participated in the AHRQ project.

"The staff at Patewood Memorial Hospital take ownership in delivering excellent patient-centered care, continually exceeding national standards. The hospital received the April 2013 Studer Group Healthcare Organization of the Month Award for its commitment to excellence," Haines adds. ■

Care coordination cuts admissions, ED visits, LOS

Complex patients are the target

Gundersen Health's integrated care coordination program, in which a team of RN care coordinators and social workers follows the 1% to 2% most complex patients through the continuum, has resulted in a 46% decrease in average length of stay and a 64% decrease in unplanned hospital admissions or emergency department visits.

The program, which has coordinated care for more than 15,000 patients since it began in 2003, also generated a 60% drop in total charges over a two-year period among patients who were enrolled in the program for at least 24 months. The program costs about $141 per patient per month.

The health system, based in La Crosse, WI, is a partnership between Gundersen Hospital and Gundersen Clinic and includes a 325-bed hospital with a Level II trauma center, and 35 outpatient clinics.

The program began as a pilot project in 2003 and now provides care coordination for about 1,500 to 1,700 patients at a time.

"We saw the opportunity to provide higher-quality, more cost-effective care for patients with complex healthcare needs and enhance their quality of life at the same time," says **Beth Smith-Houskamp**, RN, PhD, Gundersen Health's executive director of patient and family centered care.

The care coordination staff includes 19 care

EXECUTIVE SUMMARY

Gundersen Health in La Crosse, WI, has decreased the length of stay by 46% and unplanned admissions or emergency department visits by 64% through an integrated care coordination program that focuses on the most complex patients.

- Care coordinators who are nurses or social workers follow at-risk patients through the continuum, interacting with them face-to-face in the clinic or hospital and following up by telephone.
- Patients are identified for the program using a two-pronged tool that assesses both healthcare and psycho-social needs.
- Care coordinators follow the patients for as long as a year.

coordinators, all nurses, three social workers and one FTE administrative support position. The nurses have an average of 27 years of experience in sub-specialty areas such as pediatrics, hematology, oncology, high-risk obstetrics, palliative care, and medical-surgical care. Each care coordinator is responsible for 50 to 75 patients, and each social worker is assigned to about 100 patients.

Patients are identified for the program using a two-pronged screening tool that takes into account the need for clinical care and psycho-social assistance. "We added the psycho-social component because we know that often patients' ability to manage their care is affected by their psycho-social needs," she says.

Patients who have had a 14-day hospital stay, returned to the hospital within 30 days after discharge, or incurred costs of $100,000 or more are automatically referred for care coordination.

"Many patients are referred to the program because of a hospital stay, but that's not the only way to get into the program. We have a fully integrated electronic medical record that any Gundersen staff member can use to refer patients to the program from anywhere in the continuum," Smith-Houskamp says.

Reasons for referrals include multiple diseases, multiple inpatient admissions or emergency department visits, medication management issues, lack of social support, financial issues or cognitive deficits. Some patients see multiple healthcare providers and/or have non-medical problems that impede care. The program coordinates care for eligible patients from birth until death. Many of the patients in the program are Medicare beneficiaries, but the care coordinators also work with pediatric patients, women with high-risk pregnancies, and behavioral health patients. Patients with any insurance payer are eligible for the program.

The care coordinators complete an evaluation on hospitalized patients within one business day of referral and within two weeks for those who are referred as outpatients.

Once patients are enrolled in the program, the care coordinators assess the patients' ability to manage their healthcare needs, their support system, and complexity of needs to determine if patients need active care coordination or if they should monitor the patient but not provide interventions. "If the care coordinators don't perceive that hospital patients will need coordination after discharge, they monitor them during the hospital stay and review the situation until the patient is discharged," Smith-Houskamp says. The nurses also monitor high-risk patients after discharge to ensure their transition to a lower level of care has been successful.

The care coordinators interact with patients face to face while they are in the hospital and during clinic appointments and follow up by telephone and e-mail.

When patients are in the hospital, the care coordinators work closely with the inpatient care team to assist with planning for discharge and follow-up care and to assess their readiness and motivation to manage their own care in order to make sure the discharge is successful. They participate in care conferences between the hospital staff and patients and family members.

They make sure patients understand their medication regimen and have a timely follow-up appointment with their primary care physician and accompany them on their first outpatient visit to ensure continuity of care. They meet with patients receiving care as outpatients before or after provider visits and continue following them as long as needed.

The care coordinators educate patients on their conditions, their treatment plans, and what to do if they have symptoms or signs that indicate their conditions are getting worse. The health system's electronic medical record alerts the care coordinators when patients have planned or unplanned visits to a primary care provider, visit the emergency department, or are hospitalized. The care coordinator informs the emergency department physician or the primary care provider about what has been going on with the patient.

The care coordinators and social workers may work with patients for a year or longer. Often the care coordinators are the first to identify subtle changes in the patient's condition and alert the primary care provider, Smith-Houskamp says.

Social workers partner with the care coordinators to help identify and connect patients with community resources. The social workers provide a variety of assistance, including assisting patients in obtaining necessary medical equipment, arranging transportation to medical appointments, or helping them sign up for assistance with their prescriptions.

"This team-based approach to coordinated care improves the quality of life and reduces the cost burden of patients with complex health conditions," Smith-Houskamp says. ■

Hospital's proactive approach to RAs pays off

All admissions are reviewed

A proactive approach to the Recovery Auditor (RA) process has paid off for Alamance Regional Medical Center in Burlington, NC. Out of more than 800 denials from the auditor, the hospital has appealed up to the administrative law judge level, if necessary. So far, the hospital has won a high percentage of the appeals. Many are still pending because of a backlog.

"My goal is not to lose. We appeal 100% of denials, and we don't accept no for an answer," says **Anne Brewer**, RN, BSN, CCM, denial audit coordinator at the 238-bed regional medical center.

Brewer attributes the hospital's success during the audit process with the approach the hospital leadership took when the Centers for Medicare & Medicaid Services first announced the Recovery Auditor program.

The hospital created a new utilization review department to perform reviews on all admissions to make sure they meet admission criteria, no matter where they come into the hospital. In addition, the hospital assigned care coordinators to the emergency department from 3 a.m. to 11 p.m., seven days a week, to work with physicians on medical necessity and admissions status. The nurse care coordinators in the emergency department have received extensive training on InterQual criteria and updates as well as on hospital admission policies.

In addition, a utilization manager conducts a pre-surgical review to make sure the documentation is complete on all patients having elective surgery before the surgery is performed and reviews all surgical cases after the surgery to determine if surgical complications indicate medical necessity for an overnight stay.

"We are on it [medical necessity] as soon as the patients hit the door. We try to cover all the bases," Brewer says. The utilization manager meets with the admitting physicians if there are questions about medical necessity or patient status. If the question is not resolved, the case is sent to the physician advisor firm under contract with the hospital. The secondary physician advisor reviews the case and calls the admitting physician to discuss it before making a final determination if more documentation is necessary.

The team members educate the physicians any time they see missing information in the documentation and put up charts in the emergency department to remind staff what details need to be included in the documentation.

"We encourage the physicians to document what they are thinking about the patient's condition to give the complete picture to justify the orders for inpatient care. We know that if physicians order observation services for every one-day stay, we are doing it wrong," she says.

The hospital has worked with surgeons to document medical necessity for surgical procedures in the patient record. Most physician offices send over the office notes, including history and physical information as well as outpatient treatments, such as physical therapy, that have failed.

"We've had good success with asking for the information. The physicians know that while the RA reviews don't impact them now, they will in the future," she says.

Brewer checks the CMS website for updates every day to stay current on what conditions are being targeted for automated audits. She attends seminars and webinars on the RA process, and even follows CMS on Twitter.

Brewer stays on top of the conditions being targeted in Medicare's three-year Recovery Audit program prepayment review demonstration project and beefs up education on those conditions. Under the program, being conducted in 11 states including North Carolina, the Medicare Administrative Contractors (MACs) review and affirm or deny claims before they are paid. Hospitals may appeal the prepayment denials through the normal appeals process.

EXECUTIVE SUMMARY

Alamance Regional Medical Center in Burlington, NC, appeals all Recovery Auditor denials, up to administrative law judge level, and works to avoid denials by carefully scrutinizing admissions for medical necessity.

- The utilization review department reviews all admissions for medical necessity, regardless of where they come in to the hospital.
- Care coordinators staff the emergency department seven days a week and work with physicians on medical necessity and patient status.
- Computer software tracks every record request and denial and appeals quickly.

"We pay careful attention and we have done a lot of education around syncope because that was the first target for our hospital. We know that prepayment reviews for transient ischemic attacks and gastrointestinal conditions with hemorrhage are on the horizon. During our last RA audit, those were the biggest targets," she says.

When the RA program (then called the Recovery Audit Contractor Program) began, the hospital purchased computer software to track everything, she says. "We check the CMS website every day so we are not surprised with the cases being pulled for automated audits," she says.

The team tracks every record request and denial in the computer system and notifies the physician advisor or the outside physician advisory firm, depending on who reviewed the record initially. The hospital files an appeal quickly, using an outside physician advisory firm for the appeals if they reviewed the case originally. Otherwise, Brewer writes the appeals.

"When we get a denial, we have everything ready to go for the first level of appeals and send it out before the 30 days are up. We want to hang onto the money as long as we can," she says. ■

Study: Checklists can improve patient safety

When doctors, nurses, and other hospital operating room staff follow a written safety checklist to respond when a patient experiences cardiac arrest, severe allergic reaction, bleeding followed by an irregular heartbeat, or other crisis during surgery, they are nearly 75% less likely to miss a critical clinical step, according to a new study funded by the Agency for Healthcare Research and Quality (AHRQ).

While the use of checklists is rapidly becoming a standard of surgical care, the impact of using them during a surgical crisis has been largely untested, according to the study published in the January 17 issue of *The New England Journal of Medicine*.

"We know that checklists work to improve safety during routine surgery," said AHRQ Director **Carolyn M. Clancy**, MD. "Now, we have compelling evidence that checklists also can help surgical teams perform better during surgical emergencies."

For this randomized controlled trial, investigators simulated multiple operating room crises and assessed the ability of 17 operating room teams from three Boston area hospitals — one teaching hospital and two community hospitals — to adhere to life-saving steps for each simulated crisis. In half of the crisis scenarios, operating room teams were provided with evidence-based, written checklists. In the other half of crisis scenarios, the teams worked from memory alone. When a checklist was used during a surgical crisis, teams were able to reduce the chances of missing a life-saving step, such as calling for help within one minute of a patient experiencing abnormal heart rhythm, by nearly 75%, the researchers said.

Examples of simulated surgical emergencies used in the study were air embolism (gas bubbles in the bloodstream), severe allergic reaction, irregular heart rhythms associated with bleeding, or an unexplained drop in blood pressure. Each surgical team consisted of anesthesia staff, operating room nurses, surgical technologists, and a mock surgeon or practicing surgeon.

Hospital staff who participated in the study said the checklists were easy to use, helped them feel more prepared, and that they would use the checklists during actual surgical emergencies. In addition, 97% of participants said they would want checklists to be used for them if a crisis occurred during their own surgery. ■

Checklists, hand hygiene cited as top strategies

Of the hundreds, if not thousands, of patient safety strategies employed at hospitals across the country, the Agency for Healthcare Research and Quality (AHRQ) has released a report identifying the top 10 patient safety strategies that can be implemented immediately by healthcare providers.

Based on an assessment of evidence about patient safety interventions, the report finds that these 10 strategies, if widely implemented, have the potential to vastly improve patient safety and save lives in U.S. healthcare institutions. Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices assesses the evidence for 41 patient safety strategies and most

strongly encourages adoption of the top 10. The strategies can help prevent medication errors, bedsores, healthcare-associated infections, and other patient safety events.

"We have the evidence to show what really works to make care safer," AHRQ Director **Carolyn M. Clancy**, MD, said in announcing the report. "Armed with this knowledge about what works and how to apply it, we can continue to advance our efforts to ensure patient safety."

The new report emphasizes evidence about implementation, adoption, and the context in which safety strategies have been used. This evidence helps clinicians understand what works, how to apply the strategies, and under what circumstances they work best so they can be adapted to local needs. Many of the strategies already are widely in use, and some are based on CDC guidelines. Others have shown great promise, but remain uncommon in practice. The report also identifies gaps where more research can further advance patient safety.

The entire report, including evidence reviews for all 41 patient safety strategies, can be found at http://1.usa.gov/YKJXBV.

The new report was prepared by AHRQ Evidence-based Practice Centers at the RAND Corp., the University of California, San Francisco/Stanford University, Johns Hopkins University, and ECRI Institute, with input and recommendations from a team of patient safety experts.

These are the recommended patient safety strategies:

- preoperative checklists and anesthesia checklists to prevent operative and postoperative events;
- bundles that include checklists to prevent central line-associated bloodstream infections;
- interventions to reduce urinary catheter use, including catheter reminders, stop orders, or nurse-initiated removal protocols;
- bundles that include head-of-bed elevation, sedation vacations, oral care with chlorhexidine, and subglottic-suctioning endotracheal tubes to prevent ventilator-associated pneumonia;
- hand hygiene;
- the do-not-use list for hazardous abbreviations;
- multicomponent interventions to reduce pressure ulcers;
- barrier precautions to prevent healthcare-associated infections;
- use of real-time ultrasonography for central line placement;
- interventions to improve prophylaxis for venous thromboembolisms. ■

Understanding CoP anesthesia standards

AHC Media, publisher of *Hospital Case Management*, has published "Cracking the Code: Understanding the CMS Hospital CoP Standards on Anesthesia," which explains the anesthesia standards and PACU standards. The chapters are organized in the order in which the anesthesia standards are contained in the hospital CoP manual. Our book covers anesthesia services, organization and staffing, preanesthesia evaluations, the intraoperative anesthesia record and required policies and procedures, and post-anesthesia assessments. We include hundreds of pages of policies and procedures and other informative practical material you can start using immediately. The book offers 4.5 hours of continuing nursing education. For more information on this book, go to http://bit.ly/118jCoT. ■

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

- How to meet CMS requirements for discharge planning
- How healthcare literacy can affect hospital reimbursement
- What CMS proposes for fiscal 2014
- What the Recovery Auditors are up to now

CNE QUESTIONS

1. According to Beverly Cunningham, RN, MS, vice president of resource management at Medical City Dallas Hospital, in order to succeed under value-based purchasing, hospitals should have strong initiatives in what areas?
   A. Core measures
   B. HCAHPS
   C. Readmissions
   D. All of the above

2. In what year will Medicare spending-per-beneficiary be added to the Centers for Medicare & Medicaid Services Value-Based Purchasing Program?
   A. Fiscal 2013
   B. Fiscal 2014
   C. Fiscal 2015
   D. Fiscal 2016

3. Care coordinators in Gundersen Health's integrated care coordination program in La Crosse, WI, carry a caseload of how many patients?
   A. 15 to 25
   B. 25 to 50
   C. 50 to 75
   D. 100 to 150

4. As part of its proactive approach to RA audits, Alamance Regional Medical Center in Burlington, NC, assigns care coordinators to the emergency department. What days and hours do they work?
   A. Seven days a week, 3 a.m. to 11 p.m.
   B. Seven days a week, 8 a.m. to 11 p.m.
   C. Monday through Friday, 3 a.m. to 11 p.m.
   D. Monday through Friday, 8 a.m. to 8 p.m.

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. ■

CASE MANAGEMENT INSIDER

Case manager to case manager

Managing Length of Stay Using Patient Flow – Part 3

By Toni Cesta, PhD, RN, FAAN
Senior Vice President
Lutheran Medical Center
Brooklyn, NY

In the last two issues of *Case Management Insider,* we discussed issues associated with identifying and monitoring patient flow. This month we continue our discussion with a focus on the elements of patient flow associated with the inpatient setting. These issues relate directly to the provision of care as well as the progression of care for patients as they move through the acute-care continuum.

Understandably, there are a large variety of processes that touch patients as they transition through the hospital experience. Each of these processes must be evaluated individually as well as part of the larger process. Let's begin by looking at those processes most common to the inpatient experience.

Getting Started

When beginning to look at patient flow, you may not think that you have a problem with a particular process or department. However, you may want to consider starting off by doing an assessment of all relevant departments, as we will discuss below. This way your hospital can identify those areas that need work, versus those that are not problematic. This provides a baseline that should be re-evaluated annually as needed.

Pharmacy

Pharmacy turnaround times include the time from when the physician writes the order until the medication arrives to the floor. Although your hospital may not have overall issues with medication turnaround, it might want to take a look at chemotherapy turnaround or similar turnaround times for newly admitted patients. Many times the first doses of a newly admitted patient create the most delays. These delays affect quality of care as well as length of stay and can ultimately have a negative impact on patient flow. Chemotherapy administration falls into this category.

Laboratory

Throughput in the laboratory is a complex process. It involves a host of smaller processes, some of which are automated. In general, the following are the processes that should be analyzed on the initial assessment and then as needed after that.

Laboratory Turnaround Times

The first thing to consider is the turnaround time for specific tests. In working with the staff in the lab, the benchmarks for the various lab tests should be gathered. While some tests can be completed rather quickly, others may take longer. If the same expectation for turnaround time is applied to all tests, then some will always be outside the expected timeframe. Review your top blood tests with the lab and set realistic time frames for each test. Then establish the current turnaround times and focus on those tests that are outside the expected benchmarks.

The Accessioning Process

The accessioning process is the process that includes the time from when the specimen is received in the lab until it is processed and placed into the equipment for analysis. This process can get bogged down if the phlebotomists "batch" blood and send multiple specimens to the lab at the same time. The staggering

of specimen delivery can reduce the likelihood of these kinds of back-ups in the accessioning process.

The Way in Which Morning Blood Work Is Drawn and Processed

The morning blood draw process will have a direct impact on the accessioning process. If the blood is batched, this will result in a delay in all the blood work being completed. Batching blood can overwhelm the lab when an overflow of blood work comes in all at once. Staggering the blood draws on the nursing units is the first step. The next step is to have the blood sent to the lab in small batches so that the lab can keep up with the volume.

Blood Work for Discharged Patients

Another issue to evaluate is the potential delays in discharge that may occur while the team is waiting for blood work to come back. If this is a common problem in your hospital, you may want to consider labeling this blood work differently. For example, the blood tubes could be labeled with a red bar around them to alert the laboratory staff that this blood work belongs to a patient who is expected to be discharged that day. This blood work might then be expedited so that the clinical staff can get the results earlier and the patient can be discharged sooner. This process should be particularly considered on units where there is a higher percentage of "short stay" patients, such as a cardiology unit.

Radiology

Turnaround time for radiology services is another key patient flow process. Radiology encompasses so many diagnostics and treatments that it cannot be neglected when studying and assessing patient flow. The turnaround times from the physician's order until the tests are completed are the key processes that should be evaluated. Most radiology systems do not capture this information so that in the absence of an electronic medical record it may be difficult to gain this information for analysis. Most systems monitor the time from when the test was done until the results are reported. While this is an important part of the process, as case managers we are also interested in the time it takes to actually do the test after the doctor orders it. However, if you are able to get this information, it can be quite valuable.

The absolute turnaround times are vital to this analysis, but there are other variables to consider. These would include the time of the day in which the test was ordered as well as the day of the week. When looking at the day of the week, weekends should be analyzed separately as there are usually more delays on Saturdays and Sundays.

Each of these metrics should be benchmarked against the expected turnaround times, which should be determined by the radiology leadership. Each test should have an expected turnaround time that is based on industry standards. These standards can be found in the radiology literature and should be re-evaluated annually.

Because there is such a large variety of tests done in the radiology arena, you may want to consider selecting those that represent highest volume in your hospital.

Transportation

Another area to evaluate includes both internal as well as external transportation. Internal transportation has to do with the movement of patients within the hospital, including from one unit to another as well as from one department to another. When evaluating these turnaround times, patient transport from the ED should be evaluated separately from transportation within the hospital. Also to be considered are any departments or areas that use their own transportation staff. This is often true for emergency departments. These departments should be monitored separately as their turnaround times could be quite different from departments using a centralized service.

Other sub-processes might include the time to arrive to a test, versus the time to return after a test. Typically, the time it takes patients to return to their room after a test is longer because there is less pressure to get them to that location than there is to get them to the diagnostic test.

As with most processes that we are discussing, it is important to look at the time of the day and the day of the week. Staffing patterns will often dictate the turnaround time and may lead to the need for additional staffing at certain times or days.

Transportation external to the hospital is also important to consider. External transportation has to do with ambulances and other paid-

for-transportation services. When evaluating these, be sure to look at the company and the type of service as well as times of the day and days of the week. The data should also be segregated into groups that indicate whether the transportation was ordered the same day or the day before. When transportation is ordered the same day as it is needed, the wait times tend to be longer than when it is planned for the day before it is needed. This kind of information can be used when speaking to the case management and medical staff so that they can see the impact of planning for discharge the day before the patient is actually going home. Patients waiting to leave because of transportation delays can back up the ED, the PACU, and can backlog housekeeping and other ancillary services.

Perioperative Services

Perioperative services are impacted by patient flow because of patient flow delays in other parts of the hospital. Not unlike the emergency department, they are the recipients of delays downstream from them. Most perioperative services track and monitor their own patient flow data. If this is the case in your hospital, then it will be easy enough for you to tap into this data. If not, then you will have to work with the department to begin to collect it.

High-level perioperative analysis should include the following:

- the time the patient enters the operating room until the procedure starts;
- the procedure start to the procedure stop time;
- the procedure stop time to the patient exiting from the OR;
- the time from the patient exiting to the next patient starts.

When evaluating the entire perioperative process, however, one must consider more than just what happens inside the operating room. All of the perioperative processes can have a positive or negative impact on patient throughput and length of stay and are important to any patient flow analysis.

Other perioperative processes include the following:

- preadmission testing processes and delays;
- operating room turnaround times (as above);
- PACU turnaround times;
- PACU delays due to overcapacity in the intensive care or telemetry units;
- cancellation rates and reasons, including cancellations within 24 hours of surgery and within one week of surgery;
- operating room booking process.

Perioperative processes should be segregated by ambulatory surgery versus inpatient surgery. This is important because ambulatory surgery cases usually have a shorter operating room time as well as recovery time. They will positively skew data on more complex inpatient procedures and therefore should be kept separate and reported separately.

Cancellations for surgery are an important metric, as they may indicate problems with other processes such as pre-surgical testing, patient communication and education, among others.

The Nursing Department

The staff nurses and nurse managers play an important role in the management of patient flow. Many elements of patient progression are dependent on the interventions associated with direct patient care that are performed by nurses. Examples of these include:

- progressive ambulation;
- diet progression;
- patient education particularly around self-care, medications and disease processes;
- transitioning from IV to PO medications;
- pain management.

Nurse managers, staff nurses and case managers should think and function as a team when it comes to patient flow. Attending daily patient care rounds is a good way to make this happen. This is particularly true if the rounds are conducted at the bedside. By rounding at the bedside, the team can visually assess the patient in terms of their environment, i.e. foley, IV, ambulation, etc., and work together to break down any barrier in care progression. Over time, patterns of delays can be identified and corrected in a unified and collaborative fashion.

Case Management

Clearly, the case managers are the leaders in patient flow management. However, as we have seen throughout this series on patient flow, the entire case management department must work collaboratively with all departments throughout the hospital to facilitate patient flow. Patient flow is one of the key roles of the case manager.

The case manager, in the role as coordinator and facilitator of patient care, identifies and corrects patient flow barriers as they occur. In this role, the case manager ensures that delays at the point of care are identified and corrected. This unique role affects quality of care, operational efficiency, cost and length of stay. It places the case manager in a strategic position to identify and correct delays as they occur and before they become problematic. When the problem cannot be corrected directly by the case manager, the issue has to be directed to the case management leadership, the physician advisor, or the director of the department in question.

The case management department should have contacts in each ancillary department. This individual is the key contact for the department with whom the case manager can interface when something needs to be expedited. As issues are identified during walking rounds or at any point throughout the day, the case manager has a contact person to work with who has been prospectively identified. Once the issue has been identified, it should be entered into the case management database for aggregation and analysis later. The data will help to identify patterns and trends that need to be corrected on a go-forward basis.

Physician Practice

Physician practice patterns may affect as much as fifty percent of the patient flow delays in a hospital. Issues to address as they relate to the role of the physician include:

- physician practice patterns around resource utilization and length of stay;
- ventilator use for chronic patients, including weaning attempts and patterns;
- end-of-life issues such as use of critical care beds and obtaining advance directives;
- discharge delays;
- transfer issues, such as non-notification to the receiving hospital;
- misuse of the ED;
- outpatient work-ups;
- bypassing the admission process;
- bypassing the precertification process;
- critical care and telemetry bed usage;
- delays in moving patients out of critical care beds or off telemetry, thus adding to the cost of care and length of stay and reducing throughput.

Discharge

The discharge process is another key process in terms of patient flow management. Issues for consideration include:

- Discharge planning staffing patterns, particularly understaffing and/or lack of vacancy coverage for vacation/holiday or sick time coverage. Delays over the weekend will bottleneck processes on Mondays and Tuesdays. The combination of staffing shortages as well as lack of weekend coverage can both contribute to delays that will carry over into the following week.
- Discharge patterns, especially delays on weekends, holidays and evenings.
- Discharge delays associated with physician's order writing, family delays or transportation delays.
- Availability of continuing care services in the community.
- Patient financial issues such as insurance coverage for community services. These may affect the case manager's ability to obtain services in the community and may delay discharge.
- Delays associated with pre-authorization delays attributed to managed care companies or government payers.

Summary

As lengths of stay shorten across the country, opportunities to continue to reduce length of stay become more difficult to identify. Monitoring care progression processes is the foundation of patient flow and requires daily point of care monitoring as well as data analysis retrospectively.

Each case management department should create a patient flow infrastructure that includes daily monitoring and correction as well as a database that allows for collection of information that can be used later for analysis and performance improvement.

In next month's issue of *Case Management Insider*, we will review a couple of different patient flow report cards that can be used to monitor delays and bottlenecks across the continuum of care. ■