HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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AHC Media

Beef up your discharge planning processes, experts recommend

CMS surveyors will be checking for compliance

As the Centers for Medicare & Medicaid Services (CMS) continues its emphasis on discharge planning, it's more important than ever for case managers to create a comprehensive discharge plan that provides everything patients need to manage in the next level of care, some experts say.

Beginning this year, surveyors will use a discharge planning worksheet to review how hospitals comply with the discharge planning portions of the Medicare Conditions of Participation. As part of its Patient Safety Initiative, CMS has also developed worksheets to help surveyors assess compliance with the Conditions of Participation for performance improvement and infection control. The worksheets are designed to assist the surveyors and the hospital staff to identify when they are in compliance.

CMS has been pilot-testing the worksheets since 2011, according to **Sue Dill Calloway**, RN, MSN, JD, CPHRM, CCM, CCP, president of Patient Safety Education and Consulting in Dublin, OH. CMS tested the third revised surveyor worksheet in 2013 and came out

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services is increasing its emphasis on discharge planning and has developed a worksheet for surveyors to use to determine if hospitals are in compliance with the Conditions of Participation.

- Hospitals must have discharge policies and procedures in writing and must be able to show that they are following them.
- Discharge planning assessments should be comprehensive and include the patient's psychosocial needs as well as medical needs and should take into consideration whether patients can safely go back to their previous setting.
- Communication with post-acute providers is essential to create smooth transitions and identify any gaps in information.

with the final revised worksheet for discharge planning in March 2014. Surveyors will use the worksheet whenever a CMS survey is done. The updated infection control and quality improvement worksheets are expected to be finished later this year.

"The worksheets are very important, and all hospitals that accept Medicare or Medicaid reimbursement should be intimately familiar with them," Dill Calloway says. "It doesn't matter who accredits hospitals. They have to be in compliance with the CMS standards. Hospitals have to comply with the Medicare Conditions of Participation or they could be fined or lose their ability to bill for Medicare and Medicaid."

The discharge planning survey worksheet gives hospitals a step-by-step guide to what CMS expects hospitals to be doing to comply with the Conditions of Participation, but it also is a blueprint for what hospitals should be doing anyway, says **Laura Jacquin**, RN, MBA, managing director for Huron Healthcare, a Chicago-based consulting firm. "The Conditions of Participation are patient-focused, patient-centric rules that spell out the right thing to do for patients. They are very much focused on providing an effective, comprehensive discharge plan with patient safety and preventing readmissions in mind," she says.

Hospitals must have discharge planning policies and procedures in writing, but it's not enough to just have them in place; you have to be able to follow them and show that you have done so, adds **John Laursen**, managing director for Huron Healthcare.

"The challenges we see as we work with clients is operationalizing the policies on a day-to-day basis. Case managers and the entire care team need to work together. Case management can't work in isolation and expect to develop an effective discharge plan," he says.

The surveyors will be reviewing hospitals' discharge policies and procedures to determine if they meet all the requirements of the Conditions of Participation and if they are in effect for all inpatients — not just Medicare patients, Jacquin says. They will look for evidence of discharge planning activities on every unit, and if the staff are following the discharge planning policies and procedures.

Dill Calloway suggests that hospitals put together a team to review all three worksheets and complete them as a self-assessment to make sure they are doing everything that CMS requires. The discharge planning worksheet reflects the changes made in the CMS standards on discharge planning that went into effect on July 19, 2013. "CMS completely rewrote all of the discharge standards in a 39-page memo that decreased the number of standards from 24 to

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13," she adds.

CMS now publishes quarterly deficiency reports that show that many hospitals are receiving deficiencies in the discharge planning standards, Dill Calloway says. "In fact, in the January 2014 report, there were 364 deficiencies," she adds. *(The deficiency reports are available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals.html.)*

"The worksheet is a good communication tool to ensure that everybody in the organization is knowledgeable about the discharge planning standards. Sometimes the questions in the worksheet are not apparent from a reading of the CMS hospital interpretive guidelines. It is very important for every nurse, social worker, and discharge planner to be familiar with the discharge planning standards and incorporate them into their staff education and their hospital's policies and practices," she says.

The worksheet spells out what case managers should be assessing, says **Michele Kala**, RN, MS, a surveyor for the Chicago-based Healthcare Facilities Accreditation Program (HFAP), which has deeming authority from CMS.

"Case managers should be performing a complex assessment that covers everything a patient needs to be able to do in order to function in whatever setting they will be in after discharge. The assessment should spell out what the discharge planners need to do to modify the patient's living environment or arrange community resources to support the patient's medical needs," she says.

The key issue in compliance is identifying patients who are at high risk for readmission and developing a discharge plan to make sure that wherever they go after discharge, they will be able to manage in a safe manner and stay healthy and out of the hospital, Kala says. "There are no specific criteria for hospitals to use to identify the high-risk population. Case managers have to conduct a thorough assessment to identify patients who have complex problems and living situations that keep them from following their discharge plan," she adds.

Hospitals with limited resources may not have the staff to conduct a discharge planning evaluation on every patient. In that case, they should come up with a mechanism to identify high-risk patients by diagnoses, severity of illness, and psychosocial needs, Kala says. "If facilities don't have the resources to invest, it's acceptable to Medicare to create a discharge plan only for patients who are at risk," Kala says.

Jackie Birmingham, RN, BSN, MS, CMAC, vice president emerita of clinical leadership for Curaspan Health Group, a Newton, MA-based transition management software company, points out that in today's healthcare environment, patients who are admitted to the hospital tend to be very sick and are being discharged earlier than ever. "If the inpatient admission criteria set says the acute care hospital is the only place for patients to be, they should be assessed to determine where they should go next," she says.

The best practice for hospitals is to conduct a discharge planning evaluation on every patient, Dill Calloway adds. But if you don't evaluate every patient, your policies and procedures must include a process to notify patients, family members, and attending physicians that they can request one, even if the patient doesn't meet high-risk criteria, she says.

The surveyors will look for a process to notify patients that they can request a discharge planning evaluation. Dill Calloway suggests that the information be included in the patient rights and responsibilities document and that the patients be asked to sign it. The nurse can also inform the patient of his or her right to request an evaluation during the admission assessment and document it.

"Don't just hand the patients a sheet listing the patient rights. The best practice is for the registrar to give the patient the rights and responsibilities document at registration and go over the specific items," she says.

Surveyors also will be assessing how physicians are educated on their right to request a discharge planning evaluation. Information on how to order an evaluation could be included in the new physician orientation manual; the chief medical officer could issue a memo to all physicians, or there could be a presentation at the medical executive committee meeting.

"This has to be done only if the hospital doesn't perform a discharge planning evaluation on all patients," she adds.

Policies and procedures should specify when case managers or social workers are consulted, such as when patients have been admitted frequently, when the admission assessment indicates that the patient won't be able to manage at home alone, or when patients have social issues, such as no place to live, Dill Calloway says.

Your hospital should have a policy for updating changes in the condition of patients who were not immediately identified as needing a discharge plan. The surveyors will determine if the inpatient staff are aware of why and when and who should be notified if there is a change in a patient's condition, according to Dill Calloway. For instance, if case management is called in only when the admission assessment indicates the need for a discharge plan, your policies and procedures should spell out what happens when there is a change in the patient's condition or situation that warrants a discharge plan.

"When hospital case managers and nurse discharge planners see the patient or review their charts every day, this streamlines the process and ensures compliance. If this doesn't happen, your policies need to specify how the discharge planner knows there is a change that means the patients do need a discharge plan," Dill Calloway says.

The discharge planning policies were originally intended for inpatients, but CMS has added three categories of patients who may need discharge planning. The worksheet has check-off boxes for discharge planning processes for patients receiving observation services who are not subsequently admitted, emergency department patients who are not subsequently admitted, and same-day surgery patients.

"Hospitals need to have a discharge planning policy in effect for all patients, not just those who are admitted as inpatients," Dill Calloway says.

The surveyors also will review five patient records, including one who has a discharge planning evaluation with a discharge plan under development, and when possible the record of a patient who was readmitted within 30 days.

The surveyors are going to pull charts and make sure that everything specified in the conditions of participation is happening, Jacquin says. "They will look to make sure the evaluation is done by a qualified professional who completes a comprehensive assessment. They will check to see that patients have a discharge plan and that the care team is communicating on a daily basis so that the plan is updated when the patient's condition changes," she says.

When Kala conducts a survey for HFAP, she spends at least an hour with the discharge planning staff talking about the hospital's discharge planning processes and going over the charts she has reviewed. "This is an educational session as well as a fact-finding meeting," she says.

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To order the CD of Sue Dill Calloway's webinar "CMS Discharge Planning Worksheet 101" go to http://www.ahcmedia.com/public/products/CMS-Discharge-Planning-Worksheet-101.html ■

Reaching out to post-acute providers

Work with them to prevent readmissions

It's no longer enough for case managers to create a discharge plan and forget about the patient as soon as he or she is out the door, advises **Jackie Birmingham**, RN, BSN, MS, CMAC, vice president emerita of clinical leadership for Curaspan Health Group, a Newton, MA-based transition management software company.

"The hospital is just one part of the continuum of care. Case managers need to have a focused commitment to ensure that patients succeed after they leave the hospital," she says.

Making sure that post-acute providers have what they need to care for patients is an integral part of the newest version of the Centers for Medicare & Medicaid Services' discharge planning worksheets that surveyors will use to assess compliance with the Medicare Conditions of Participation, according to **Sue Dill Calloway**, RN, MSN, JD, CPHRM, CCM, CCP, president of Patient Safety Education and Consulting in Dublin, OH.

When patients are transferred, the transfer form must include a brief reason for hospitalization, the course of treatment, the patient's condition at discharge, a medication list, allergies, pending laboratory work, and a copy of the advance directives. "These items are mandatory, not optional," she says.

Surveyors will check to ensure that the discharge summary was sent to the patient's primary care physician before the first follow-up

visit or within seven days of discharge if no follow-up appointment was made, Dill Calloway says."Case managers should document the appointment for the follow-up visit and make sure that the discharge summary gets into the hands of the primary care provider. Hospitals need to do this even though it is a 'blue box advisory,' which means it is highly recommended but the surveyor won't cite the hospital if it isn't done. This process is important to prevent unnecessary readmissions, which cost hospitals with a higher-than-average readmission rate $217 million dollars this year," she says.

Hospitals need to communicate regularly with staff from post-acute facilities to make sure they are receiving the information they need to care for patients at the next level of care in a timely fashion when patients transition, Dill Calloway says.

"Hospitals are trying to find creative ways of getting this kind of information without making it problematic. Some send out questionnaires. At other facilities, the case managers contact the post-acute providers for feedback. Others have regular meetings with the post-acute providers to talk about what could be done differently," says **Michele Kala**, RN, MS, a surveyor for the Chicago-based Healthcare Facilities Accreditation Program.

The Conditions of Participation also mandate that hospitals analyze their 30-day readmissions to find the cause and determine what could have been done to avoid the readmission. If hospitals do not track their readmissions as part of discharge planning, they will be cited, Dill Calloway says.

A more introspective look

The surveyors also will look to see if the hospital made changes to the planning process as a result of potentially preventable readmissions. "CMS wants hospitals to take a more introspective look at the causes for potentially avoidable readmissions and to make changes to improve their processes," Kala says.

When patients are readmitted for the same condition within 30 days, find out why. For instance, don't just look at whether the patient got the prescription filled; drill down to find out if the patient was taking the medication as prescribed, Kala suggests. Then give patients the resources they need to follow their plan.

Kala tells of one hospital that interviewed patients readmitted with heart failure and found that a sizable number of patients weren't weighing themselves because they didn't have scales. "The solution was simple: The hospital starting giving heart failure patients digital scales," she says. ■

CMS mandates better DP earlier in the stay

Take time to find out what's up with patients

The discharge planning worksheet that surveyors will use to assess hospitals' compliance with Medicare Conditions of Participation highlights the need for case managers to be more proactive in discharge planning and identifying the right post-acute setting in a timely fashion, says **Laura Jacquin**, RN, MBA, managing director for Huron Healthcare, a Chicago-based consulting firm.

"Case managers should be doing better planning earlier in the stay," she adds. She recommends that case managers screen all patients for high risk factors at the time of admission. Look at age, diagnosis, mental status, comorbidities, polypharmacy issues, financial or social challenges, potential living arrangements and support after discharge, understanding of the disease process and medication regimen, and what post-discharge care they will need, she says.

"You want to make sure the surveyors see that all these questions are built into your assessment process and that case managers spend the time it takes to ask them," she says.

People who are doing discharge planning should take an in-depth look at patients' abilities to manage in the place to which they will be discharged and ask the right questions to determine if they can be compliant in that environment, adds **Michele Kala**, RN, MS, surveyor for the Healthcare Facilities Accreditation Program.

It's not enough to pop in, check off the boxes for a three-minute questionnaire, and arrange services. Discharge planners have to assess the patient's ability to be compliant and put them in the best environment to make it happen, she says.

When case managers perform a discharge evaluation, they should include an assessment of whether the patient can go back to where he or she was before admission, says **Jackie Birmingham**, RN, BSN, MS, CMAC, vice president emerita of

clinical leadership for Curaspan Health Group, a transition management software company based in Newton, MA.

"The Centers for Medicare & Medicaid Services (CMS) doesn't want hospitals to just send patients back to the same level of care. If a patient meets acute care admission criteria, they are very sick and something in their care plan has to change. CMS wants discharge planners to pay more attention to assessing patients for continuing care needs," she says.

It's logical to assess patients differently depending on where they came from, Birmingham says. "Patients who came from a skilled nursing facility may have different reasons for the admission than patients who came from the home environment. Case managers need to drill down and find out why patients were admitted," Birmingham says.

Look at the whole gamut of care patients have been receiving and collaborate with the attending physicians to decide where they should go next based on where they came from, Birmingham says.

One of the big holes in the discharge planning process is the lack of communication between nursing and case management, Birmingham says. "When nurses complete the initial assessment, they know which patients are likely to have complex needs and they should alert case management," she says.

John Laursen, managing director for Huron Healthcare, suggests daily patient progression rounds during which the entire care team gets together and talks about every patient. "The discussions can be as short as 30 seconds for some patients but should include the patient's condition, discharge disposition, and the plan for the day. These meetings allow the care team to get on the same page," he says.

"I'm seeing more and more hospitals investing resources in interdisciplinary walking rounds where the staff talk about each patient and their discharge needs. Communication is phenomenal during these rounds, and everybody gets a discharge plan," Kala adds.

Discharge planners should interact with patients and get their input on the discharge plan, says **Sue Dill Calloway**, RN, MSN, JD, CPHRM, CCM, CCP, president of Patient Safety Education and Consulting in Dublin, OH. "You can't just produce a discharge plan and hand it to patients. You need to talk to them about the plan and ask them to repeat it. There are 90 million Americans with low health literacy. Discharge planners need to make sure they understand what they are supposed to do," Dill Calloway says. She adds that English is not the primary language for 50 million Americans, so hospitals should use interpreters as needed.

She suggests that case managers make an appointment for a patient to see his or her primary care provider after discharge. "The timing is critical. One study has shown that readmissions were reduced if the patient has a follow-up appointment within one to four days after discharge," she says.

There are some patients who are going to be noncompliant no matter what you do, Kala points out. "But most patients don't want to be noncompliant. They just don't have what they need to follow their discharge plan. It's a matter of flushing out all the issues and determining the best post-discharge setting and finding the resources they need," she says. ■

Extending hospital to the primary care office

Nurses follow patients for 30 days post-discharge

A program in which care transition specialist nurses follow patients for 30 days after discharge and support them in adhering to their treatment plan is reducing readmissions at Beth Israel Deaconess Medical Center in Boston.

"We're seeing encouraging signs from this program. We have tried a lot of different ways to reduce readmissions, from revising our discharge paperwork to setting up follow-up appointments. The whole process showed us how complex a problem readmissions are," says **Laura Doctoroff**, MD, FHM program director.

The program started with a small pilot project in which two nurses followed about 250 patients who were treated at the hospital-based primary care practice. Patients in the pilot were hospitalized with heart failure, pneumonia, or acute myocardial infarction.

Following the success of that program, Beth Israel Deaconess applied for and received a $5 million Center for Medicare & Medicaid Innovation grant to launch a Post-Acute Care Transitions (PACT) program. The hospital expanded the program to target patients treated at six practices and who were hospitalized for all diagnoses.

All Medicare patients who are treated by

CASE MANAGEMENT INSIDER

Case manager to case manager

Community Case Management – Thinking Beyond the Hospital Walls

By Toni Cesta, PhD, RN, FAAN

Introduction

When the Centers for Medicare & Medicaid Services (CMS) changed the way in which it would reimburse hospitals based on the number of Medicare 30-day readmissions they had, hospitals began a long journey of discovery. Initially, most of us thought that acute care hospitals would be in the control seat in terms of reducing the number of patients readmitted to the hospital with heart failure, acute myocardial infarction, or pneumonia. Certainly we could do better in many ways in terms of how we prepared patients for transition back into the community. Soon, however, we also discovered that there were wide gaps in care delivery for patients once they returned to the community, especially for those patients at highest risk for readmission, emergency department visits or other negative outcomes.

This month, we will be discussing the opportunities for better care coordination and case management of our most vulnerable patients living at home. These patients are small in numbers perhaps, but they consume large percentages of health care dollars. The greater the number of chronic conditions a patient has, the greater the number of health care resources he or she will consume. We have always assumed that this was inevitable and expected. Until CMS created reimbursement penalties, hospitals had no financial incentive to reduce the number of these patients readmitted to the hospital. In fact, hospitals were financially rewarded for patient failures in the community. Today, many states are beginning to enact similar financial penalties for higher than average readmissions within their Medicaid programs, and it is expected that many managed care plans will soon follow suit.

High-risk Patient Case Management

High-risk case management in the community provides for an opportunity to improve patient quality of care and quality of life while reducing the overall cost of care. It requires that we see the patient and family at the center of the health care system, not the hospital. It also requires that case managers develop long-term and lasting relationships with the highest risk patients. And case managers must think in terms of the continuum of care and consider the management of the patient regardless of their location along that continuum. Case management thereby moves from an episodic approach such as it is in hospitals and home care delivery models, to a continuous and strategic long-term one.

The relationship between the patient and the case manager is germane to any future care delivery models. It includes the identification of these patients, the identification of the factors placing these patients at risk, the development of plans of care that include the patient and family, and the management of precious health care resources.

Integrating Case Management Roles

When redesigning the case management department to add a community case management component, one of the first steps is to create a department that transitions across the continuum of care. The infrastructure must be designed this way, just as the case managers must approach their work this way. While the

acute care case manager manages that episode of illness, there must be consideration for the fact that the goal is to return that patient to the community, preferably back to his or her home environment when appropriate. Even patients going to sub-acute for a period of time will eventually be returning to their homes. Therefore, as the patient transitions out of the acute care setting, the goal is to ensure that all possible pieces have been put into place to reduce the likelihood of a return to the ED or hospital setting.

The hospital case manager must perform an assessment that includes a comprehensive understanding of the conditions from which the patient was admitted. It must also include an understanding of what failed in the patient's community health care management that resulted in this negative outcome. Every admission to the hospital must be seen as a failure, and a root-cause analysis should be done to determine what action steps must be taken to prevent another readmission to the hospital. Clearly not every admission will be avoidable, but many of them will be, depending on the patient's specific high-risk criteria.

Identification of High-risk Patients

The identification of the high-risk patient can happen in one of two ways. It can happen proactively, by identifying these patients while they are still in the community, or it can happen once the patient has had multiple encounters with the health care system, particularly emergency department visits or acute hospital admissions or readmissions.

From a practical point of view, it is likely that both approaches will need to be used. Even if a patient scored low risk in the community and then was admitted to the hospital, something in his or her clinical condition or social situation may have changed or deteriorated, resulting in the visit to the hospital.

Conversely, as patients enter the community system, either the clinic or physician's office, an assessment can be performed there that will categorize the patient as low, moderate or high risk. Risk level criteria can vary, and there is a variety of schools of thought as to what places some patients at higher risk than others. One starting point can be to select the diagnoses that are resulting in the most readmissions to your hospital. You may also want to focus on the diagnoses that CMS is focusing on for readmission penalties. Right now, these include heart failure, acute myocardial infarction, and pneumonia, but CMS will be adding more each year.

Using this approach, you can track patients with these diagnoses and then add additional risk factors to the equation. Additional risk factors might include the following:

- number of hospital admissions in the prior six months;
- number of hospital readmissions in the prior six months;
- number of co-morbidities;
- age;
- socioeconomic status;
- health literacy;
- ability/willingness to be compliant.

A combination of risk factors and chronic diagnoses will ensure that you have selected the highest-risk patients. No single element listed here alone can place a patient at high risk, but rather some combination of elements. If a patient has heart failure but is adherent to her diet and medication regimen, she will not need to be classified as high risk. If another patient has heart failure, but routinely winds up in the hospital because he does not take his medications or goes off his diet restrictions, then this patient may need to be classified as high risk. Both patients have heart failure, but one needs much closer case management than the other.

If approximately 5-10% of your patients fall into the moderate-risk category, you are likely on the right track in terms of your indicators. If the percentage turns out to be higher than that, then you may want to tighten up the criteria unless you have the resources to manage larger numbers of patients.

Moderate Risk

Another 20% of your patients should fall into the moderate-risk category. This is sometimes also referred to as the "rising risk" category as it represents patients who may be on the cusp of becoming high risk if an intervention does not take place. These patients typically do not need professional case management in the form of a registered nurse or social work case manager. They can be managed via telephonic reminders, electronic monitoring of their blood work and appointments and occasional check-ins if

appointments are missed.

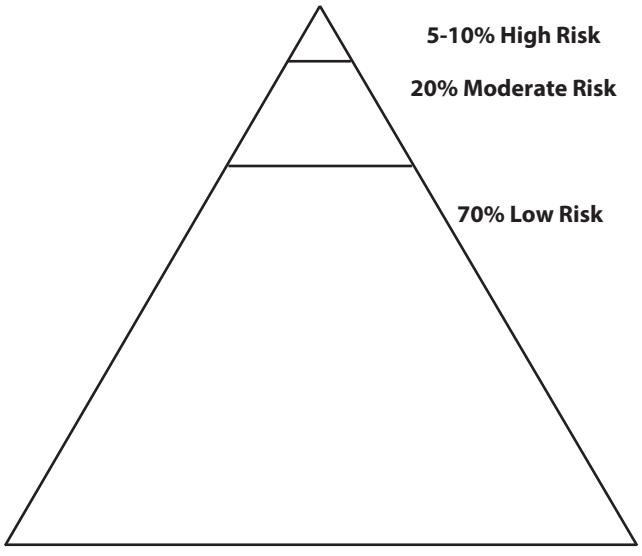
These patients should be reassessed for risk level if they have a hospitalization, a visit to the emergency department, miss multiple appointments or have worsening of their medical condition. Additional factors may include new comorbidities, a change in socioeconomic status, or an acute illness.

Case management staff in the emergency department or hospital can play an important role in helping to identify patients whose risk level has changed. This identification can take place when the patient is initially assessed. At that point, a contact should be made with the community case management department to determine what additional case management services the patient might require.

Risk levels are fluid. Patients may increase or decrease in risk level at any point. For example, if a high-risk patient has not been hospitalized or been in the emergency department for a six-month period and his or her clinical status is improving, this patient may be appropriate for a down-grade to moderate risk. Conversely, the patient who is moderate risk and has any of the changes listed above may need to be upgraded to high risk. According to The Advisory Board Company, approximately 18% of the rising-risk or moderate-risk patient population will become high-risk in any given year. (Playbook for Population Health, www.advisory.com/pophealthplaybook.)

Low Risk

The remaining 70% of patients fall into the low-risk category. These are patients who have none of the risk factors as described above and who are generally stable and self-managing. They may be completely healthy individuals. They may have chronic conditions that are well-maintained.



These patients are as important as the moderate- to high-risk patients in terms of keeping them healthy and stable. They need to be connected to the health care system, as should all patients. As providers, our goals for these patients would include providing a level of care and involvement with these patients that keeps them loyal to our health system or medical home. We want to keep them as healthy as possible by ensuring that annual routine check-ups take place and that these patients don't fall through the cracks. By maintaining a database on the low-risk patient population, your system or medical home is in a better position to treat them should care be needed at any point.

The best way for these patients to interact with the health system is through a patient portal where they can participate in the management of their care and interface with the health care system or medical home.

Patient Registries

Patient registries are another important tool for managing high- and moderate-risk patients. These are clinical information systems that provide a foundation for actively following large numbers of patients. Registries provide a technology solution to managing large populations of patients. For low-risk patient groups, they can be used to trigger patient appointment scheduling, routine blood work or annual tests such as mammograms or colonoscopies.

For moderate-risk patients, the registry can be used to trigger the above, plus additional clinical management issues that may be specific to the moderate-risk patients. These may include more frequent appointments with the primary care provider. Beyond these issues, the moderate-risk patient may need monthly telephonic or face-to-face meetings with the social worker and/or case manager, depending on their issues.

For the high-risk patient, they will need to have their blood work monitored closely as well as any other frequent tests or procedures that need to be performed. The software can alert the case manager when blood work results are abnormal or when a patient does not keep

a scheduled appointment. Expected outcomes can be entered into the patient's database so that all care providers know the patient status and can review, with all of them looking at the same information in the system. In addition, the social worker and case manager will need to keep a close and diligent eye on their status and progress.

Finally, registries can be used to assess populations of patients to determine how your organization is doing in terms of any and all of the issues listed above. These data can be used to identify areas for improvement, gaps in care, or other issues requiring intervention or improvement.

The Role of the Acute Care Case Manager in Community Case Management Systems

Acute care case managers can no longer work in siloes, isolated and apart from the rest of the health care continuum. Solutions to many of today's care delivery issues, such as transitions in care, readmissions, and recidivism, require that case managers based in hospitals keep an eye on the patient's pre-admission issues and post-discharge needs. This begins with an assessment of the patient's risk level as discussed above.

When your patient is admitted to the hospital, your initial admission assessment should include an analysis of the patient's prior living situation, including family and other support systems. If the patient is a readmission within 30 days, then it is imperative that you assess what the root cause(s) of this readmission were. This is an important part of your admission assessment because it will determine the following:

- If the patient's clinical condition is worsening.
- If you need to make a referral to the social worker.
- If the patient can return to their prior living situation. (Is it safe?)
- If the family caregiver is adequate.
- If the patient is unable to manage his or her medications at home.
- If the patient is unable to manage his or her diet at home.

In addition to gathering this information, you should check your electronic medical record (EMR) to determine who the patient's primary care provider is in the community and what the risk level of the patient is. Your system should be set up so that the patient's prior risk stratification level is available to you as well as the assigned community provider, case manager, and social worker, if appropriate. Once you have gathered this information, then you can notify these providers regarding the patient's admission, and issues that preceded the return or admission to the hospital. It is also recommended that the community case manager and/or social worker visit the patient in the hospital. This approach to coordination of care, as well as continuity of care, can result in fewer gaps or redundancies in care. Ultimately, these interventions can provide the care team with the information they need to improve the patient's clinical situation and/or quality of life.

Summary

Case managers must approach the case management process as one that focuses across on the continuum of care and addresses inpatient as well as community needs. Case management assessments must go well beyond just the issues of discharge destination, but rather connect the care providers across the continuum in new ways that will improve outcomes for patients and reduce cost for the healthcare industry. ■

the six primary care practices and admitted to the hospital as inpatients are enrolled in the program, with the exception of oncology, psychiatric, and obstetrical patients. Patients receiving observation services are not included in the program. "We know that it's sometimes hard to determine which patients are at risk for readmission, and that's why we enroll almost all patients," she says.

"We chose very different practice sites, including an academic practice that employs residents, a community health center, and private practices. Everybody in the hospital has medical needs. We wanted to find out how the model works for patients with readmission risks based on psychiatric or social issues as well as medical conditions," Doctoroff says.

The hospital tied its readmission reduction program to primary care practices because that's where patients are being seen during the critical weeks after discharge, Doctoroff says. "Physician practices are in the best position to prevent readmissions. In the hospital, we touch patients for only a short period of time. Even if we develop a great discharge plan, it can fall apart unless somebody is there to support the plan after discharge," she says.

The program has eight full-time nurses and four pharmacists. They are supported by a social worker whose position is funded by a private foundation. The nurses are assigned to primary care practices and collaborate with primary care providers on helping the patients manage their conditions and adhere to their treatment plans after discharge. "When they work with one primary care practice, the nurses develop a relationship with the physicians and office staff, they learn how the practice works, and become an extension of the primary care office into the hospital," Doctoroff says.

The nurses visit the patients in the hospital and conduct an assessment that includes how well patients understand their condition, what kind of support they have in the home, how compliant they have been with their treatment plan in the past, how many times they have been hospitalized for the same condition, and other factors that may contribute to their risk for readmission. If patients have complicated social situations or need community resources, the nurses can call on the social worker for assistance.

After patients are discharged, the care transition specialist nurses follow them, mostly by telephone, for four weeks. They make sure the patients have gotten their prescriptions filled, understand how to take their medicine, and that they are taking it. They make sure the patients have a follow-up appointment and have transportation. The frequency of the interventions is based on patient need, Doctoroff says. For instance, a patient who had a total knee replacement may need only a phone call once a week to check on pain control and how physical therapy is going. On the other hand, if a heart failure patient is struggling to understand the treatment plan and diet, the nurse may call several times a week.

The pharmacists conduct medication reconciliation on admission and ask questions to determine patient adherence. When patients are about to be discharged, they conduct medication reconciliation again and educate patients on their medication regimen. After discharge, the nurses get the pharmacists involved if patients are having medication problems.

When patients are discharged to a skilled nursing facility for rehabilitation, the pharmacists follow up when patients are being discharged from that facility. "They conduct medication reconciliation with the medication list from the skilled nursing facility and obtain a complete list for the primary care physician. This is invaluable for the physicians because medications are changed so frequently as patients go through the continuum," Doctoroff says.

The nurses typically are following up with 40 to 45 patients at a time. Whenever possible, the nurses see the patients in person when they come back to their primary care physician or when they see a specialist. "The nurses who

EXECUTIVE SUMMARY

Using a Centers for Medicare & Medicaid Services Innovation grant, Beth Israel Deaconess Medical Center in Boston launched a program to prevent readmissions.

- Care transition specialist nurses are assigned to six primary care practices and work with patients in the practice to which they are assigned.
- They meet patients in the hospital and follow them for 30 days after discharge.
- The program includes pharmacists who conduct medication reconciliation and work with patients on medication issues, and a social worker who is called in when patients have psychosocial needs.

work with the primary care providers based in our hospital clinic have an easier time seeing patients in person. For the case managers who work with other practices, it's more practical to follow the patients by telephone," she says. ■

HF readmissions drop after initiatives

Team examined transition process

Before Essentia Health-St. Joseph's Medical Center in Brainerd, MN, began its heart failure readmission program in 2011, the hospital's 30-day readmission rate was 18%. Now, it's been consistently less than 10% and had dropped to 6% in December 2013.

"Our goal is to continue our efforts to improve transitions and keep heart failure patients out of the hospital. Keeping patients healthy at home after a hospital stay is not only the right thing to do for patients to improve their quality of life, it's also the right thing for the hospital as the Centers for Medicare & Medicaid Services (CMS) and other payers are penalizing providers financially when patients are readmitted," says **Kathryn Miller**, RN, BS, G-L C, director of quality and safety at the 162-bed acute care hospital.

Some of the initiatives the hospital adapted include making primary care appointments before patients leave the hospital, follow-up phone calls after discharge, creating admission and discharge order sets that list the standard best practices, medications, and issues that need to be addressed for heart failure patients, and developing a close relationship with post-acute providers.

The hospital began working with Stratis Health, the Minnesota Quality Improvement Organization (QIO) in mid-2011 to analyze readmissions and come up with a plan to reduce unnecessary readmissions within 30 days of discharge.

"We determined that we had an opportunity to reduce the readmissions for heart failure. We examined the whole transition process and learned the best way to impact the long-term recovery and health of the patient is to make sure the patient and the receiving provider have all the information they need to keep on track with recovery after the patient leaves the hospital," she says.

The hospital convened an interdisciplinary group of social workers, discharge planners, nurse directors, hospitalists, pharmacists, and other disciplines and reviewed data on readmissions. In addition, St. Joseph's invited the directors of nursing from the three largest nursing homes in the area, home care and hospice representatives, and representatives from other community agencies to meet regularly. One agency that participated was the Senior Linkage Line, an organization that provides services for Minnesota seniors free of charge, including answering questions about Medicare, helping with prescription drug assistance, providing information on long-term care options, and a variety of other services. A representative from Stratis Health also attends the meetings.

A key to the success of the initiative was developing rapport with post-acute providers, and it took just one simple change to get them on board, Miller says.

At the first meeting, skilled nursing facility representatives informed the hospital that their regulations require that every medication dispensed be tied to a diagnosis and that it often took several phone calls and faxes to get that information after the patient arrived.

"We immediately educated the hospitalists to include a diagnosis-related reason for each medication in the chart. It didn't take long to make that change, and the nursing facilities immediately realized how productive these meetings could be," Miller says.

The hospital has always provided an interagency transfer form along with key documents such as the discharge summary, progress notes, and lab and other test results, Miller says. The report includes the patient's last medication and what

EXECUTIVE SUMMARY

By analyzing heart failure readmissions and collaborating with post-acute providers and community organizations, Essentia Health-St. Joseph's Medical Center in Brainerd, MN, cut its readmission rate from 18% to a low of 6%.

- An interdisciplinary team analyzed readmissions, interviewed patients who were readmitted, and developed the program.
- Initiatives include setting primary care appointments while patients are in the hospital, following up after discharge, and creating order sets that include best practices.
- The hospital staff meet regularly with post-acute providers and social service agencies to brainstorm ways to create smoother transitions and ensure that patients get what they need after discharge.

time it was given and the last set of vital signs. In addition to providing the paper documents, the hospital has worked with the information technology staff to allow directors of nursing or social workers at the nursing homes to access patients' hospital records on a view-only basis if they need additional information during the hospital stay.

When patients are discharged to another level of care, the nurse at the hospital calls the receiving nurse, gives an oral report and answers questions. If the patient is going to a provider who is not part of the hospital system, the attending physician also calls the physician at the receiving facility.

When the team spoke with heart failure patients who were readmitted, they found that many had not had a follow-up appointment with their primary care provider. "We know that patients who have a follow-up visit with their physician within five days are less likely to be readmitted because the doctor can identify and deal with any problems," Miller says. The team also determined that often patients weren't able to get appointments because their doctor had no openings for several weeks. The hospital worked with the staff at the clinics to establish one to two available appointments every day for patients being discharged from the hospital, Miller says.

Now the ward secretary calls the physician practices and sets up timely appointments for patients who are being discharged. "We have found that if we make the appointment, patients are much more likely to go," Miller says. In addition, the discharge planners meet with patients before discharge to address any concerns the patients may have, such as lack of transportation to the doctor's office for their follow-up appointment. If they do not have transportation or can't fill their prescriptions because of financial hardship, the discharge planners may refer them to the Senior Linkage Line for assistance. The agency can arrange transportation by volunteers who will take patients to the pharmacy or physician office, or connect them with financial assistance programs that may be able to help with prescription co-pays.

Two days after patients with certain chronic diseases are discharged, a nurse calls to check on them. The nurse, who has access to the patients' medical record, makes sure they understand their condition, that they have their medication and a follow-up appointment, and that they have transportation to the doctor's office.

The hospital has a pharmacist in the emergency department to complete medication reconciliation for patients who are being admitted so the treatment team will have the most accurate list possible before the patient gets to the unit.

"It's not always easy to get an accurate list of medications since some patients use multiple pharmacies and others are snowbirds who get their prescriptions filled while they are in Florida or Arizona for the winter. The pharmacist is the best person to get this information so that the physicians treating the patient are informed," she says. ■

Nurses at high risk of work-family conflict

One solution: self-scheduling

Nurses are at high risk of stress caused by work-family conflict (WFC) partly because of the physical and emotional demands of their long shifts. One solution could be to permit some worker self-scheduling, an expert says.

Nurses who worked in hospitals that provided a policy of self-scheduling were very satisfied with the policy and credited this for making their work-family lives more flexible. The increased flexibility also helped them take better care of their own health, according to a recent study.[1]

"Basically, just the nature of nursing work is stressful," says **Mira Grice Sheff**, PhD, MS, assistant professor at SUNY Downstate Medical Center in Brooklyn, NY.

"Twelve hour shifts are common, and nurses work evening shifts," she adds. "There are a lot of staffing shortages that some hospitals report makes the work more stressful."

Studies show that many health care professions are at high risk for stress and WFC, including medical technicians, radiation therapists, social workers, occupational therapists, physicians, and nurses.[2]

"Work-family conflict is a worker issue," Sheff says. "Any worker who has limited decision-making about the schedule and limited flexibility and long working hours will be at risk, too; doctors fall in this category, and radiology technicians and other workers also are at risk."

A new study in the *Journal of Occupational Health Psychology* suggests that workers who fail to psychologically detach from stressful events in the workplace are at greater risk of work-family conflict.[3]

Hospitals could help workers improve detach-

ment and alleviate stress through encouraging more organizational communication so employees have no ambiguity or conflict with their roles, helping employees participate in decision-making, and granting employees greater independence with meaningful and timely feedback, according to the Management Study Guide's Web guide on strategies for managing workplace stress.

In research conducted by the National Association of Social Workers, the top three personal methods for social workers to alleviate stress are exercise, meditation, and therapy.[4]

Also, demographics play a role. Older nurses in their 40s or 50s generally are more likely to be taking care of aging parents as well as children, and this can contribute to WFC, Sheff says.

A new study in *Gerontology* found that middle-aged adults are engaged in multiple life domains simultaneously and this can lead to conflict between those different demands, particularly for women. For instance, women reported more psychosomatic symptoms when they had conflict between their work and family domains.[5]

Sheff has looked into how WFC is impacted by changes health systems make, including allowing self-scheduling, which her research suggests is a popular solution.

"With self-scheduling, employees have some input, and while it's not a guarantee of their getting the schedule they need, it does give them a little bit of flexibility that is necessary for balancing their home responsibilities with work obligations," Sheff explains.

Work-related stress caused by work-family conflict has been noted in literature for more than two decades.

After the Family Medical Leave Act was passed in the early 1990s, research into WFC took off, Sheff notes.

Nationally, the problem became more noticeable as greater numbers of women, including working mothers, entered the workforce and were forced to balance their professional responsibilities with their family roles, she adds.

"With WFC, there are two directions that it can go: You can have work interference with home, and you can have home interference with work," Sheff says. "It depends on the work environment and personal issues in a worker's life, but nurses generally report more work interference with the family, and that, generally speaking, is what you see in the literature."

What research suggests is that workers experiencing this stress are less productive, have more turnover, and it leads to decreased quality of care and increased errors with patients, Sheff says.

"Unhappy workers will not work as well; they might call in sick more and they might make more mistakes," she adds. "For these reasons, employers should be concerned about the stress workers are experiencing."

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ER nurses decry silence after violence

Little support from leadership

"Nothing changes, nobody cares." That bleak title of a recent journal article tells the story of workplace violence through the eyes of emergency room nurses.[1]

Reams of surveys have documented the frequency of verbal and physical assaults in the nation's emergency rooms. But researchers with the Emergency Nurses Association (ENA) went beyond the statistics to learn about the nature of these assaults — and the impact they have on nurses.

The qualitative study gathered narratives from 46 emergency nurses. The researchers asked them simply: "Tell me about your experience of violence in the emergency setting." Their responses ranged from a single page to 15 pages.

A common frustration ran through the narratives related to a lack of support from hospital leadership to address violence and unwillingness of public offi-

cials to pursue charges against violent patients.

"This perceived lack of concern about nurses' safety resonated throughout the narrative accounts," the authors stated. "Participants described unsafe work environments, where safety measures were put into place (such as security cameras or panic buttons) but were not maintained or enforced … A few participants had been assaulted more than once and were frustrated by the lack of any real change in security or environmental protective measures."

The narratives also reflected a failure to recognize or address cues related to high-risk patients or situations. Incidents often involved patients under the influence of alcohol or drugs, with a history or violence or mental health issues. Long wait times and overcrowding were common issues.

Understanding the nature of violence in the emergency room is a first step toward addressing the problem, says **Deena Brecher**, MSN, RN, APN, ACNS-BC, CEN, CPEN, ENA president.

"No silence on violence," she says. "We can't stop talking about it. In order to effect a change, it's really important to understand why is this so prevalent and why is it not changing."

Many nurses themselves accept verbal and minor physical assaults as part of the job, says Brecher. That attitude can change with a "zero tolerance" policy toward assaults and an emphasis on reporting incidents, she says. "Any health care provider in any organization should not be assaulted, period," she says.

ENA advocates training of nurses and periodic assessment of the workplace violence hazard. (*A free toolkit is available at* www.ena.org/practice-research/Practice/ViolenceToolKit/Documents/toolkitpg1.htm.)

The response of ER nurses to violence varied from fear and trauma to resignation. Some nurses reported injuries that caused recurring pain.

ENA supports workplace violence prevention laws, which have been passed in 10 states, Brecher says.

"If we all start talking about it and we all work to change the culture, then we'll change it," she says.

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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 have a conversation about hospice.

■ How your peers are reducing readmissions.

■ The next step in value-based purchasing.

■ Redesigning CM to increase efficiency.

CNE QUESTIONS

1. According to Sue Dill Calloway, RN, MSN, JD, CPHRM, CCM, CCP, president of Patient Safety Education and Consulting, the Centers for Medicare & Medicaid Services completely rewrote all of the discharge planning standards in 2013 and reduced the number of standards from 24 to how many?
   A. 20
   B. 15
   C. 13
   D. 10

2. According to Jackie Birmingham, RN, BSN, MS, CMAC, vice president emerita of clinical leadership for Curaspan Health Group, one of the big holes in the discharge planning process is lack of communication between nursing and case management.
   A. True
   B. False

3. Care transition specialist nurses at Beth Israel Deaconess Medical Center in Boston follow patients for 30 days after discharge. How many patients at a time do they typically follow?
   A. 10-15
   B. 20-25
   C. 30-35
   D. 40-45

4. How long after discharge do nurses telephone patients in Essentia Health-St. Joseph's Medical Center's readmission reduction program?
   A. Two days
   B. Five days
   C. One week
   D. 10 days

Hospital Report blog

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

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