HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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Discharge planning takes spotlight as VBP focuses on efficiency

Next level of care is increasingly important

Beginning with admissions on or after Oct. 1, 2014, your hospital's reimbursement under the Centers for Medicare & Medicaid Services (CMS) Value-based Purchasing Program is going to be affected by how much a patient's care cost for the time period beginning three days before admission and continuing through 30 days after discharge.

"The expectation is for hospitals to pay attention to what happens to patients before admission, such as observation services as an outpatient, and the services they receive for 30 days after discharge. Hospitals need to ensure that patients are discharged to the setting that can provide the most effective care and that the transition goes smoothly," says **Danielle Lloyd**, MPH, vice president, policy development and analysis for Premier healthcare alliance.

Medicare spending per beneficiary, also called hospital efficiency of care, makes up 20% of a hospital's value-based purchasing score

EXECUTIVE SUMMARY

Hospital efficiency of care, a new domain in the Centers for Medicare & Medicaid Services Value-based Purchasing Program, bases hospital scores on spending three days before admission through 30 days after discharge.

- Case managers need to take the time to develop a discharge plan that works and look at cost-effectiveness as well as appropriateness of the level of care, experts say.
- Because the data used for this measure is risk-adjusted, it's crucial for the documentation in the medical record to clearly and accurately reflect the patient's severity of illness.
- Become familiar with all the potential discharge destinations and spend time with each provider, experts recommend.

in fiscal 2015 and will rise to 25% in fiscal 2016.

Hospitals' scores on the hospital efficiency of care measure that affect the fiscal 2015 payment period have already been tallied and are posted on CMS's Hospital Compare website. The website shows the ratio for each individual hospital compared with the state average and national average.

Medicare spending per beneficiary includes all Medicare Part A and Part B expenditures except for Part B drugs beginning three days before admission and continuing through 30 days after discharge. Hospital scores are based not just on Medicare costs while patients are in the acute care hospital but for expenditures during the whole window of time. Any payment Medicare makes on behalf of a beneficiary is included. If patients are transferred to another hospital, if they go to a skilled nursing facility or are discharged home with home health, it's all added into the total.

In value-based purchasing, the measurement period is well in advance of the payment period. "Hospitals didn't have much opportunity to impact what they will be paid for hospital efficiency of care in fiscal 2015. They have to work on improving their performance in the future," says **Susan Wallace**, MEd, RHIA, CCS, CDIP, CCDS, director of inpatient compliance for Administrative Consultant Services, a Shawnee, OK-based healthcare consulting firm.

Risk adjustment

Case managers should recognize that CMS is risk-adjusting the data used to calculate Medicare spending per beneficiary based on what is coded on the bill, Wallace adds.

Factors for risk adjustment include age, gender, past medical history, and other diseases or conditions that could increase their risk.

"Since the data is risk-adjusted, it's important for the documentation to clearly indicate the severity of illness. Case managers should make sure that physicians include detailed information on all of the patients' diagnoses to accurately reflect severity of illness," she says.

Case managers can have a major influence on their hospital's efficiency scores because the discharge plans they create and the effectiveness of transitions to the next level of care affect what it costs Medicare to provide services after discharge, says **Jackie Birmingham**, RN, BSN, MS, CMAC, vice president emerita of clinical leadership for Curaspan Health Group.

Hospitals have the opportunity to ensure that patients go to the right place the first time, she says.

"Case managers need to start thinking like

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finance managers," Birmingham says. "It's not necessarily the right thing or most efficient thing to discharge patients to the least expensive level of care. Patients need to be discharged to the appropriate level of care that can provide everything they need to continue their recovery," Birmingham says.

Case managers should start looking at what is best for the patient in the long run, and sometimes that's not just getting them out as quickly as possible, she says.

"Earlier discharge is good, but in today's reimbursement environment, case managers also need to look at other things. If the discharge plan fails and a patient is readmitted, the cost of care can soar since often the readmission costs more than the original hospital stay," she says.

CMS has expressed concern that hospitals often discharge patients with complex needs to skilled nursing facilities because it is easier than lining up all the equipment and therapy the patients would need if they were discharged to home, she says.

That's why case managers need to consider all options, including keeping patients in the hospital a little longer to cut down on post-discharge expenses, she adds.

The emphasis on creating a successful discharge plan increases the need for collaboration between case managers and the rest of the hospital team, particularly if the case management role and the discharge planning role are separate, says **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services, a Shawnee, OK-based healthcare consulting firm.

"If you have a case manager facilitating care in the hospital and a discharge planner who develops a discharge plan, communication between the two is vital in order for the discharge plan to take into account the social issues and the clinical issues," Hale says.

As CMS puts more emphasis on the cost per beneficiary, case managers need to consider all the options available for the patient, according to Hale.

Hospitals will be forced to come to a point when they look at what post-acute option will be the most economical as well as most effective — a skilled nursing stay or home health services; inpatient rehabilitation vs. rehab at a skilled nursing facility, she says.

Medicare spending per beneficiary does not change the fact that patients have freedom of choice about post-acute providers, Lloyd adds. "Case managers, physicians and others working with the family can provide additional quality information about providers or can use risk assessment tools to determine where patients should be placed, but that doesn't change the fact that beneficiaries get to choose where they go," Lloyd says.

CMS' emphasis on the entire episode of care should encourage more relationship-building across care settings and more collaboration across provider types, Lloyd says.

In order to succeed under value-based purchasing, hospital staff members must work together as a team to develop a discharge plan that takes the patient's medical and psychosocial needs into account and then collaborate with the providers at other levels of care to ensure that the plan succeeds, Lloyd says. ■

Focus on readmissions just keeps increasing

Hospitals penalized when patients come back

Readmissions are a big factor in Medicare spending per beneficiary since an additional hospital stay adds significantly to the total cost of care, points out **Susan Wallace**, MEd, RHIA, CCS, CDIP, CCDS, director of inpatient compliance for Administrative Consultant Services, a Shawnee, OK-based healthcare consulting firm.

In effect, value-based purchasing penalizes hospitals twice for readmissions—once in the readmission reduction program and again in value-based purchasing, since the cost of a readmission typically is more expensive than the original admission.

Hospitals need to be assessing every patient who is readmitted to find out why he or she came back and taking steps to avoid making the same mistake twice, she adds.

Look at readmissions and break down where patients were admitted from and their discharge destination. Then drill down and determine why patients were readmitted, what their discharge plan was, and where they were before they were readmitted.

Jackie Birmingham, RN, BSN, MS, CMAC,

vice president emerita of clinical leadership for Curaspan Health Group, advises hospitals to also examine the readmission rates of each post-acute provider and determine if patients will be referred to providers with high rates of readmission.

In some cases, it may be that the provider wasn't the best choice for the patient, she adds.

Hospital case managers need to be familiar with what kind of care each post-acute provider gives so they can determine the right one, Birmingham says. For instance, skilled nursing facilities and acute rehabilitation facilities both may provide physical and occupational therapy, but patients are appropriate for one setting but not the other. Long-term acute care hospitals and inpatient rehabilitation both provide a hospital level of care, she adds.

The case manager should determine the appropriate level of care, then find organizations that can provide that level of care and give the patient a choice, she says. However, hospital case managers often don't know enough about post-acute levels of care to provide patients with a list of the appropriate type of provider from which to choose, she says.

Invite the intake coordinators from post-acute providers to meet with the case management staff to describe the services they provide and which patient are appropriate and which are not, Birmingham suggests.

She advises case managers to visit the post-acute facilities to which they discharge patients and to spend time with a home health nurse. "If case managers never have made a home health visit, they can't imagine what homebound people go through for simple things, like getting prescriptions filled or grocery shopping. Case managers who have never worked in a particular environment, like a skilled nursing facility, need to visit the ones where they're sending patients and find out what they are like," Birmingham says.

Make sure whoever does your patient education lets patients know what to expect at the next level of care, Birmingham says. "Some patients who are discharged with home health may think they are going to have a nurse 24 hours a day or a health aide seven days a week. If they don't have the support they need, their discharge plan may fail. If patients are discharged to a skilled nursing facility and they don't like it, they may give the hospital a low score on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which also affects a hospital's value-based purchasing scores," she says. ■

Look ahead to succeed under VBP

New metrics are being added every year

It's too late for case managers to affect their hospitals' reimbursement under the Centers for Medicare & Medicaid Services Value-based Purchasing Program for fiscal 2015. Instead, case managers should look to the future and take a proactive approach to ensuring that patients receive cost-efficient care, says **Danielle Lloyd**, MPH, vice president, policy development and analysis for Premier healthcare alliance.

The performance periods for value-based purchasing that affects reimbursement for fiscal 2015 all concluded by Dec. 31, 2013. The performance period ends by Dec. 31, 2014, for everything included in the fiscal year 2016 payment period.

"Value-based purchasing is fairly new, and new metrics are being added every year. Hospitals can't wait until the payment year to take steps to improve their quality. Any measure in the Inpatient Quality Reporting Program is considered to be on deck for inclusion in value-based purchasing," Lloyd says. She advises case managers to be aware of what measures are being tracked because they are likely to become part of value-based purchasing.

The goal of Medicare's Value-based Purchasing Program is to reward hospitals for providing higher-quality care. Here's how it works: For fiscal 2015, starting with admissions on or after Oct. 1,

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) is adding new metrics to its Value-based Purchasing Program each year, and case managers should look ahead to ensure that their hospital performs well on the measures.

- CMS automatically withholds a percentage of the Medicare base operating payment each year (1.5% in fiscal 2015), and hospitals can earn back what was deducted or more by performing well.
- Value-based purchasing for 2015 includes four domains: clinical processes of care, outcomes, Hospital Consumer Assessment of Healthcare Programs and Systems (HCAHPS), and hospital efficiency of care.
- Any measure that is in the Inpatient Quality Reporting Program is considered to be on deck for value-based purchasing.

2014, CMS will automatically deduct 1.5% of the Medicare base operating payment.

The program is budget-neutral so the total withheld from all hospitals will be distributed as incentive payments to hospitals that perform well. "Hospitals can earn back what was deducted and more. Those that score well can do really well," says **Susan Wallace**, MEd, RHIA, CCS, CDIP, CCDS, director of inpatient compliance for Administrative Consultant Services, a Shawnee, OK-based healthcare consulting firm.

In the value-based purchasing program, hospitals are given an achievement score and an improvement score, with the higher score used to determine whether hospitals will get a bonus and how much it will be, Wallace says. The achievement score compares the hospital's scores during the performance period with the scores of all hospitals from the baseline period. The improvement score compares the hospital's score in the performance period with the same hospital's score during the baseline period.

For fiscal 2015, value-based purchasing includes four domains, 12 clinical processes of care measures, five outcomes domain measures, the eight Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey measures, and one efficiency measure. For fiscal 2015, the payment is based on the following ratios: HCAHPS 30%; processes of care 20%; outcomes 30%; and efficiency of care 20%. Efficiency of care makes up 25% of the scores in 2016.

CMS is expanding value-based purchasing each year, points out **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services. "The first year, hospitals were rated on processes of care and some patient satisfaction measures. In 2014, CMS added outcomes. The efficiency measure is an added slice of the pie," she says.

The program started in 2013 with a 1% reduction in Medicare base operating payments and will rise to 1.75% in fiscal 2016 and 2% in fiscal 2017, she adds.

"Value-based purchasing is not going away. Hospitals have to develop the mindset that this is the way it is and act accordingly," Hale says.

In the Value-based Purchasing Program, CMS is moving away from emphasizing process-of-care measures to an emphasis on outcomes measures, Lloyd points out. "Process measures will make up only 5% of value-based purchasing in 2017, down from 70% when the program started. Value-based purchasing is becoming less about whether the physician or nurse did certain things at the proper time and more about the care team being successful," she says.

For fiscal 2018, CMS has announced plans to add three care transition measures in the HCAHPS to the value-based purchasing program. They already are part of the Inpatient Quality Reporting Program, Lloyd says.

"These care transition measures are yet another example of the emphasis on care coordination and care transitions," Lloyd says.

CMS also has announced possible new episodes of care measures that may be added into the efficiency domain in future years. These six new measures include three medical episodes: kidney/urinary tract infection, cellulitis and gastrointestinal hemorrhage, and three surgical episodes: hip replacement/revision; knee replacement/revision; and lumbar spine fusion/refusion.

"This is a signal from CMS that they are continuing to emphasize efficiency measures that cross domains. This is always a place where case managers can play a role," she says. ■

Documentation must be complete and accurate

Hospital reimbursement may be affected

Case managers need to make sure their discharge documentation is accurate and complete in order for their hospitals to receive the reimbursement they are entitled to, says **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services, a Shawnee, OK-based healthcare consulting firm.

"The number-one reason for underpayment identified by the Recovery Auditors has been incorrect discharge status code assignment," she says.

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If discharge documentation isn't complete and accurate, coders may not use the correct discharge status code, which could affect a hospital's reimbursement.

- Discharge status codes identify where patients go after discharge.
- If patients go to some settings before the geometric mean length of stay, a hospital may receive reduced reimbursement.
- The Centers for Medicare & Medicaid Services has also issued a new set of discharge status codes that indicate scheduled readmissions.

A discharge status code is a two-digit code that identifies where a patient goes at the conclusion of the hospital stay. The hospital's claim for payment must include a discharge status code for both data collection and certain payment reductions, Hale says.

CMS has selected 275 MS-DRGs for which reimbursement may be financially impacted based on where patients are transferred. "CMS felt the acute care facility should not be entitled to the full MS-DRG payment if the patient would require services from other agencies also paid by Medicare," Hale says.

When a patient is transferred to certain settings before the geometric mean length of stay, minus one day, the hospital receives reduced reimbursement. Discharge settings affected include a skilled nursing facility, rehabilitation hospital, cancer or children's hospital, home with home health services, long-term care facility, psychiatric hospital, or critical access hospital, according to Hale.

If patients are transferred to another acute care hospital one day prior to the geometric mean length of stay, payments may be reduced for all MS-DRGs, she says.

Case managers need to make sure the discharge notes have complete information on the discharge destination so the coders can apply the correct discharge status codes, Hale says.

Coders use a two-digit code to indicate where a patient goes after a hospital stay. CMS requires patient discharge codes for inpatient hospital claims, skilled nursing claims, hospital outpatient claims, and home health and hospice claims. "The code the coder chooses depends on what the physician and the case manager documents. Sometimes coders have difficulty getting the information they need for the case management documentation," Hale says.

For instance, if the documentation says "discharged to XYZ" and the facility has skilled and non-skilled beds, the coder doesn't know whether to use discharge status code 03 or 04, which can affect the payment the hospital receives, she says.

CMS recently issued a new set of 15 discharge status codes to indicate when patients have a planned acute care hospital readmission. Case managers should make sure that the planned readmission is noted on the discharge documentation, Hale says.

"Despite the addition of these discharge status codes for expected readmission, CMS has not yet verified that the 'planned readmission codes' will be considered when calculating overall readmission rates. With accurate claims data, hospitals should expect CMS to further evaluate the impact of planned readmissions on the hospital's overall readmission rate and adjust payments accordingly," Hale says. ■

CMS emphasizes quality patient care

Proposed IPPS rule asks for input

In the Inpatient Prospective Payment System (IPPS) proposed rule for fiscal 2015, the Centers for Medicare & Medicaid Services (CMS) continued its emphasis on readmissions and patient safety and beefed up its initiatives that base reimbursement on quality improvement.

"Case managers can have a real impact on their hospital's performance as CMS shifts its focus from basing reimbursement on quantity to reimbursing hospitals for better care and achieving better outcomes," says **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services, a Shawnee, OK-based healthcare consulting firm.

The proposed rule, issued April 30, reduces payments when certain hospital-acquired conditions occur and readmissions are more frequent than expected. CMS also announced potential changes to the Value-based Purchasing Program. After reviewing comments from the public, CMS will issue the final rule for fiscal 2015 by August 1. The rule will go into effect with discharges on or after Oct. 1, 2014.

In addition, the proposed rule asks for public

EXECUTIVE SUMMARY

The Inpatient Prospective Payment System proposed rule for fiscal 2015 continues the Centers for Medicare & Medicaid Services' move toward basing reimbursement on quality of care, not quantity.

- The rule also asks for public input on the two-midnight rule and a policy to address short-stay patients.
- CMS is implementing the Hospital-Acquired Condition Reduction Program, which penalizes hospitals that perform poorly.
- The agency proposes to add two safety measures to value-based purchasing in the future.

input on changes to the controversial two-midnight policy, implemented in the final rule for fiscal 2014, which establishes a benchmark of two midnights for an appropriate inpatient admission.

As part of a bill to stave off scheduled cuts to Medicare physician payments, Congress delayed Recovery Auditor reviews of the two-midnight policy until after March 31, 2015, and directed CMS to work with members of the healthcare profession to develop a policy to address short-stay patients who need inpatient services but don't need to be in the hospital over two midnights.

The proposed rule asks for input on how to define short inpatient stays and how to determine an alternative payment methodology for short stay inpatient cases.

In fiscal 2015, CMS proposes to implement the Hospital-Acquired Condition Reduction Program as required by the Affordable Care Act. This means that hospitals with the poorest performance (those in the bottom 25%) in the program will have their Medicare payments reduced by 1%, according to Hale.

The program tabulates hospital scores using two domains. The Patient Safety Indicator 90 is a composite of eight measures including pressure ulcers, iatrogenic pneumothorax, central venous catheter-related bloodstream infections, postoperative hip fracture, postoperative pulmonary embolism or deep venous thrombosis, postoperative sepsis, postoperative wound dehiscence, and accidental puncture or laceration. Domain 2 measures are two healthcare-associated infection measures—central line-associated bloodstream infection, and catheter-associated urinary tract infections, according to Hale.

"Data for the Hospital-Acquired Condition Reduction Program is risk-adjusted, which means that documentation should be complete and detailed and accurately reflect the severity of the patient's illness, as well as identify any conditions that were present on admission," Hale says.

The proposed rule increases the penalty for the Hospital Readmissions Reduction Program to up to 3% for hospitals that experience excess readmissions within 30 days after discharge. In the past, the readmissions reduction program included acute myocardial infarction, pneumonia, and heart failure. In 2015, CMS is adding chronic obstructive pulmonary disease and total hip/total knee arthroplasty.

CMS proposes to add coronary artery bypass graft to readmission reduction in fiscal 2017.

In 2015, hospital payments will automatically be reduced by 1.5% to fund the CMS Value-based Purchasing Program. In the proposed rule, CMS estimates that $1.4 billion will be dispersed to hospitals based on how well they perform on the value-based purchasing metrics.

In the proposed rule, CMS announced its intention to add two measures to the new patient safety domain in value-based purchasing: methicillin-resistant *Staphylococcus aureas* bacteremia and *clostridium difficile* infection. ■

Redesign promotes patient-centered care

New role includes elements of CM, charge nurses

With the dual goals of increasing operational efficiency and promoting patient-centered care, Northwest Community Hospital in suburban Chicago revamped its care delivery model, adding a new role of clinical care coordinator to facilitate smooth and timely transitions from admission to discharge.

"We were looking for an opportunity to transform the hospital's culture to be both performance-oriented and patient-centered. We wanted to give people tools for real-time performance improvement but to focus on patient care as well as increasing efficiency," says **Pat Stack**, vice president for performance improvement at the 496-bed hospital.

"We weren't an inefficient hospital. Our average length of stay was 4.1 days. We didn't make the changes because we had a problem but because we had an opportunity to become more efficient," she says.

A key component of the model is the new role of clinical care coordinator, which combines some of the responsibilities of the case manager and some elements of the charge nurse or team leader role. The clinical care coordinators are responsible for validating patient status on admission, ensuring that patients receive tests and procedures in a timely manner, and discharge planning.

The clinical care coordinators in the emergency department work with physicians to ensure that patients are in the right status. When patients are admitted, the unit-based clinical care coordinators make sure that patients receive the recommended tests, take the lead in the discharge planning process, and spend time with patients and families to find out the information needed to create an effective

discharge plan. They can call in a social worker if the patient or family has social or economic issues and complex discharge needs.

"The clinical care coordinator is the go-to person for patients, particularly in the area of discharge planning. In the past, we had a lot of activity on the front end to assign patients to beds and a lot of activity at the last minute. Now we start discharge planning at admission so there are no surprises and the patient and family know the anticipated discharge date and discharge destination from the beginning," Stack says.

Clinical care coordinators cover the hospital 24 hours a day, seven days a week. They are assigned by unit and are responsible for between 15 to 20 patients depending on acuity. Those on the night shift cover multiple units.

The hospital kept the utilization management role but removed it from the clinical care coordinator responsibilities. "The utilization management nurses are still responsible for concurrent reviews and compliance," she says.

Each day, the clinical care coordinators facilitate what they call a Status Now Action Plan huddle during which the multidisciplinary team discusses each patient's discharge plan, what tests and procedures are pending, and what barriers could prevent a timely discharge. The team assigns one member to make sure that schedules for procedures are expedited so the patient can be discharged on time.

Creating the new roles and getting staff buy-in was a challenge at first, Stack says. "There was some skepticism about how it would work. We spent a lot of time developing the role and recruiting people to become clinical care coordinators," she says. Some of the clinical care coordinators are experienced case managers. Others are clinical experts in specific areas but have not been case managers. All of the clinical care coordinators went through four weeks of intensive training before taking on the role.

As part of the performance improvement efforts, the leadership team picks a system to improve and every clinical unit uses Lean methodology to work on how to improve the process on their own unit. Every unit has a frontline leader trained on performance improvement who spearheads the effort with the support of an operational coach. Every other Tuesday, the executive team visits every inpatient unit to check on the progress.

"The idea is that we want everybody to work on local improvement. We want them to work in-depth on areas where they have total control. We are looking at the individual unit projects to determine which can be rolled out housewide," Stack says.

For instance, the first project aimed at reducing length of stay from the time the discharge order was issued until the bed was available for the next patient. "Some units started to focus on areas outside of their control, like having environmental services come in quicker, but we wanted them to concentrate on things they could improve," she says.

The team on the mother-baby unit created a "Ticket to Ride" program that allows new mothers to pick the time they want to leave. "We don't want to be perceived as pushing patients out before they're ready, but we want to reduce variability," Stack says. The staff found that almost all of the new mothers wanted to leave during the day shift. As a result, the hospital was able to reduce the evening nursing staff because there were fewer patients on the unit.

"We look at the impact these projects have on one unit. On one unit, it might not be significant, but if we take it housewide, it makes a big difference," she says.

The hospital also implemented technology that incorporates information such as projected length of stay, tests, and procedures into the bed board system and gives the staff real-time access to everything that is scheduled for each patient each day and the anticipated discharge. The information is on the bed board in the nurses' station as well as on all the computers and mobile work stations.

"We had a good bed board in place that allowed us to follow processes like bed assignments and anticipated discharge. With this new technology, we also can keep track of what is going on with the patient and track the anticipated length of stay. The clinical care coordinators can look at the board and see what needs to happen before a patient can be discharged, but it does more than that," Stack says.

For instance, schedulers can set priorities for procedures depending on when the patient is expected to be discharged. It allows physicians to see when their patients are going to be off the unit for procedures and schedule a visit when they know the patient will be in the room. If a physical therapist needs to spend time with a patient, he or she can block off a period of time and ensure that the therapy session won't be interrupted.

"The technology has been an aid in our efforts to improve efficiency, but it's only part of the solution. We've also had to transform the culture of the hospital. We have created a workforce of problem solvers. People now are conscious of the fact that patients are waiting for services. Even though they are in the bed, patients want to be cared for efficiently," she says. ■

Transitional care nurses help prevent readmits

Communication is key to program success

At MedStar Franklin Square Medical Center in Baltimore, discharges are facilitated by a multidisciplinary transitional care team, led by a transitional care nurse who fosters communication between disciplines and collaborates with post-acute providers to ensure that transitions are smooth and timely.

All-cause readmissions have dropped from 10.43% in fiscal 2013 to 8.8% in the spring of 2014. Heart failure readmissions dropped by 2% in the same period, says **Jan Lear**, RN, ACM, director of case management at MedStar Franklin Square Medical Center in Baltimore.

"The transitional care nurses are a key to the success of the program. As coordinators of the unit-based transitional care team, they make sure everything is in place for a safe and effective discharge and that patients have appropriate post-discharge interventions," Lear says.

The hospital's readmission reduction program focuses on the diagnoses most frequently readmitted, including myocardial infarction, heart failure, pneumonia, vascular surgery, chronic obstructive pulmonary disease, and chronic renal disease. Care for patients with those conditions is managed by a multidisciplinary team led by a transitional care nurse. Other team members include representatives from nursing, case management, social work, pharmacy, and a home care representative, Lear says.

The hospital's readmission reduction program started on the cardiac unit with heart failure and myocardial infarction, says **Debbie Steelman**, RN, MS, transition team leader.

The heart failure team meets four days a week and reviews all the patients in the hospital with heart failure or myocardial infarction. They discuss what the discharge disposition is likely to be, go over every patient and determine what the barriers are to discharge, and any services the patients will need after discharge.

The cardiology physician champion meets with the team once a week and attends walking rounds with patients the team has identified as benefiting from extra teaching. "The team goes into the patients' rooms as a group and discusses the diagnosis, what treatment patients are getting, what they need to do to manage their condition, and encourage them to ask questions," Steelman says. A cardiologist from MedStar Franklin Square Medical Center also rounds weekly on heart failure and chronic obstructive pulmonary disease patients who have been transferred to a subacute facility with which the hospital has partnered.

The pharmacists on the team provide medication reconciliation and education to high-risk patients. They fill new prescriptions for discharging patients and offer a hotline number patients can call after discharge if they have questions or concerns, Steelman says.

The team has three options for post-discharge interventions. Patients who are debilitated and need more intense therapy may be transferred to a subacute rehabilitation facility. If patients require less intense monitoring, they are referred to MedStar Visiting Nurse agency or the home health agency of their choice. Patients who are referred to a subacute facility or home health must meet Medicare requirements for coverage. Those who do not qualify or require one of the options are discharged home and followed for 30 days by the transitional care nurse, she says.

The transitional care nurse sees patients while they are still in the hospital and begins providing education using the teach-back method. The goal of the education is to instruct patients on what they can do to manage their condition, Steelman says.

The nurses give patients a heart failure booklet that reinforces the education they receive in the hospital and has a place for patients to record their daily weight and symptoms. They encourage the patients to take the book with them to their physician appointment, she says.

The team has determined that teaching heart failure patients how to weigh themselves is critical to the success of the discharge, Steelman says. "Some patients weigh themselves at different times of day and wearing clothing of different weight. This does not give an accurate picture of their condition. We teach them to weigh at the same time and dressed the same way. If they don't have a scale at home, the hospital can provide one at a discounted price," she says.

The transition care nurses follow up with patients three to five days after discharge and call them back periodically, depending on the patient's needs, for 30 days. They encourage patients to get a follow-up appointment with their primary care physician or specialist. Patients who can't get in to see their doctor within five days can come to the hospital's Transition Clinic, which opened in the spring and is staffed by nurse practitioners.

"We tried making appointments for the patients

while they were still in the hospital but got a lot of resistance. A lot of times, they didn't know their schedule or they had to arrange for someone to take them," Lear says.

The transitional care nurses make sure the patients have gotten their prescriptions filled and are taking their medication correctly, reinforce education, and communicate with the patient's primary care physician or specialists about the hospitalization and the treatment plan, Lear says.

If patients are struggling to follow their discharge plan or need more support, the nurse can arrange for a home health nurse to make a one-time visit at no charge to the patient. "It's helpful to have another set of eyes on the patient," Lear says. "The nurse can make sure they know how to weigh themselves, perform medication reconciliation, and check the refrigerator and cabinets to see if there are problems with their diet. The nurse visits have been very valuable, not only to help the patients with their immediate needs but to determine when patients need extra education or assistance."

When patients are being discharged with home health, the transitional care team works closely with MedStar VNA to facilitate a smooth transition to home and to make sure patients have all the resources they need to manage after discharge. When needed, the home care nurses can set up telemonitoring devices to check blood pressure and weight to keep track of how patients are doing in between visits. They communicate with the patients' physicians when there is a change in condition, Steelman says.

The hospital has developed a partnership with Genesis Healthcare, which operates a subacute rehabilitation facility. Representatives from the hospital and the subacute facility have developed collaborative programs for chronic obstructive pulmonary disorder and heart failure to provide continuity in the teaching and standards of care as patients transition, she says.

The transitional care team is working with Genesis Healthcare to develop a palliative care program and has added a hospice liaison to the team. "We've noticed that many of our heart failure patients in their 80s and 90s still are in full code status, even if they are in the final stages of the disease, because no one has had the conversation about comfort care," Lear says. "Patients often are stuck in a cycle of exacerbation and treatment, then exacerbation and rehospitalization all over again. We are working to evaluate patients for appropriateness for comfort care and make them aware of the option. We feel this is very important for quality patient care."

When patients who have been discharged within 30 days come into the emergency department, the case managers work with physicians to explore options to readmitting them. The hospital's software system alerts the case manager when patients who have been discharged from the hospital within 30 days come to the emergency department. "The case manager reviews the medical record to find out the patient's discharge destination and works with the physician to decide if the patient can be stabilized and discharged to the subacute rehabilitation facility they were just discharged from rather than being readmitted," Lear says. ■

Statewide effort cuts readmissions

Participants focus on smooth transitions

Readmissions are not just a hospital problem. They are a problem that extends across the continuum of care, and providers at all levels of care must work together to solve it, says **Tania Daniels**, PT, MBA, vice president of patient safety for the Minnesota Hospital Association. The hospital association is a partner in the Reducing Avoidable Readmissions Effectively (RARE) campaign.

A broad-based coalition of 83 Minnesota hospitals and 93 community partners across the continuum of care, RARE has prevented 6,211 readmissions, helping patients spend a total of 24,844 more nights at home over the period starting Jan. 1, 2011, through the second quarter of 2013.

The Reducing Avoidable Readmissions Effectively (RARE) campaign has also reduced estimated inpatient costs by more than $40 million, according to Daniels.

The initiative was a joint project of the hospital association; Stratis Health, the Medicare Quality Improvement Organization for Minnesota; and the Institute for Clinical Systems Improvement. The partners collect and analyze data and provide education and coaching to each participating hospital.

The partners arranged for hospitals to participate in educational events on three models for reducing readmissions: Care Transition Intervention, developed by Eric Coleman, MD, MPH, and his team at the University of Colorado; Project RED (Re-Engineered Discharge) developed at Boston University Medical Center; and Safe Transitions, a program piloted in 2011 by 13 Minnesota hospitals under the direction of the hospital association.

The hospital association assisted each participating hospital in conducting an organizational self-assess-

ment to determine what kind of patients were being readmitted and why. Then they analyzed the data to determine where the processes need improvement, developed a plan, and implemented strategies using resources and tools provided by the RARE partners.

"We learned early on that there is not one place for hospitals to start. The projects depend on the needs of the organization, and their interests," says **Kattie Bear-Pfaffendorf**, MBA, CPHQ, patient safety and quality specialist for the Minnesota Hospital Association.

The RARE initiative focuses on five key areas that can result in readmissions if they aren't managed well. The areas are comprehensive discharge planning, medication management, patient and family engagement, transition care support, and transition communications, Daniels says.

Hospitals should start planning the discharge as soon as the patient arrives at the hospital instead of waiting until the last minute. Focus on ensuring that all of a patient's needs are considered and included in a comprehensive discharge plan with input from the patient and family, Bear-Pfaffendorf says.

"Medication management is one of the areas that has been most challenging because it's not always easy to get a comprehensive list of medications," she says. Some hospitals call the patients ahead of time to get a list. Others call after discharge. She suggests making sure that patients understand the purpose of the medications they are prescribed and take them in the correct manner at the correct time. When patients need to use inhalers or self-injected drugs, hospitals should provide comprehensive training and allow patients to practice with empty containers, she says.

Hospital staff should engage patients and family members in the discharge plan early in the stay and begin teaching long before discharge. "There is no time that's too early to start education. We encourage hospitals to start working with patients and family members as soon as possible so they will retain more information," Daniels says. Engage patients and families on their literacy level and use the teach-back method to make sure they understand what you're telling them. Use standardized materials written in plain language.

To meet the goal of transition support, some hospitals created the position of care transition coach, who meets with the patients in the hospital and follows up with a visit to their home. Some hospitals have partnered with the area's emergency medical technicians to visit recently discharged patients when they have down time. One hospital has arranged with a local college for students in nursing, pharmacy, and medical assistance programs to do home visits.

Hospitals found they needed to improve communications when patients transition between levels of care, Daniels says. "Preventable readmissions require improved care coordination between hospitals and community partners. We're working to increase communications and improve care transitions," she says.

For instance, some hospitals were sending post-acute providers discharge summaries that were 50 to 100 pages long, with key information buried in the document. The partners developed a list of 23 core elements that hospitals are encouraged to include in discharge summaries that are 21 pages or less. Key information that post-acute providers need includes current health status, follow-up needs, pending test results, red flags, medications, and special patient needs, says Daniels. ■

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- Why you should conserve your patients' benefits.
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CNE QUESTIONS

1. CMS has added a new hospital efficiency of care domain to value-based purchasing. What percentage of a hospital's score does it affect?
   A. 7%
   B. 10%
   C. 20%
   D. 25%

2. According to Danielle Lloyd, MPH, vice president, policy development and analysis for Premier healthcare alliance, CMS's Value-based Purchasing Program is shifting away from an emphasis on process of care measures to an emphasis on outcomes measures.
   A. True
   B. False

3. What is the average caseload for clinical care coordinators at Northwest Community Hospital in suburban Chicago?
   A. 15 to 20 patients
   B. 20 to 25 patients
   C. 25 to 30 patients
   D. 30 to 35 patients

4. How long do the transitional care nurses at MedStar Franklin Square Medical Center in Baltimore follow patients after discharge?
   A. 72 hours
   B. two weeks
   C. 30 days
   D. 60 days

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

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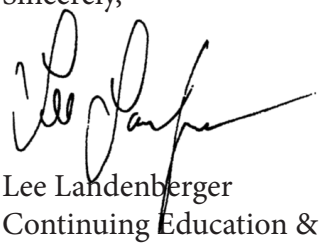

Lee Landenberger
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