HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

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INSIDE

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Change mindset to succeed in evolving world of healthcare

Emphasis on quality means a new way of doing things

With the implementation of healthcare reform's far-reaching initiatives, healthcare in this country is changing at dizzying speeds, and the role and mindset of case managers will have to change as well if they are to adapt to the new world, experts say.

"Healthcare delivery and reimbursement are changing drastically and creating new challenges and models for case management services. Mandates for quality now have financial implications, and the care coordination skills of nurses, social workers, and others will be the solution for much of the alignment necessary. Success for every segment of the continuum is going to take dramatically different ways of thinking about case management," says **Karen Zander**, RN, MS, CMAC, FAAN, president and co-owner of the Center for Case Management in Wellesley, MA.

In just the last few years, the Centers for Medicare & Medicaid Services (CMS) has moved from reimbursing hospitals for quantity toward basing

EXECUTIVE SUMMARY

The Affordable Care Act and other healthcare reform measures are making far-reaching changes to the way healthcare works, and hospitals and case managers are going to have to change their way of thinking to succeed, experts say.

- Several initiatives by the Centers for Medicare & Medicaid Services are moving toward basing hospital reimbursement on performance on quality measures.
- Instead of focusing on getting patients out as quickly as possible, case managers must look at what happens to patients after discharge.
- Hospitals are going to have to change from choosing the cheapest post-discharge setting to looking at which provider can do the best job for each individual patient, experts say.

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payment on the quality of care hospitals provide and has stated its intentions to continue moving in that direction.

After the Patient Protection and Affordable Care Act was passed by Congress in 2010, CMS announced its Value-based Purchasing Program to reward hospitals for providing quality care, beginning in fiscal 2013. Initially, scores were based on processes of care and the patient experience. In the fiscal year beginning Oct. 1, 2014, 50% of hospitals' scores are based on outcomes and efficiency, 30% on the patient experience, and only 20% on processes of care.

This year, CMS added a new domain to value-based purchasing. Hospital efficiency of care, also known as Medicare spending per beneficiary, bases hospital scores on spending during an entire episode of care starting three days before admission through 30 days after discharge. In fiscal 2015, the measure will make up 20% of a hospital's value-based purchasing score. The figure will rise to 25% in 2016.

Penalties in the Hospital Readmission Reduction Program rose to 3% in fiscal 2015, and CMS added chronic obstructive pulmonary disease and total knee and hip arthroplasty to the program and proposes adding readmissions for coronary artery bypass graft in fiscal 2017.

In addition to those changes, the CMS Innovation Center, which was created by the Affordable Care Act, is piloting the Bundled Payments for Care Improvement Initiative, which pays a fixed price or lump sum for health services by multiple providers over a specified period of time or episode of care.

The latest initiatives by CMS are big game-changers for healthcare and for case managers, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in Dallas-based Case Management Concepts.

"Medicare spending by beneficiary and bundled payments involve length of stay and the cost of the case, and both are owned by case management. This is where case managers can have the biggest impact," she says.

Medicare's new focus on quality and efficiency means that case managers must change their focus from concentrating on getting patients out the door as quickly and safely as possible to planning the transition and looking beyond hospital walls, says **Catherine M. Mullahy**, RN, BSN, CCRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY-based case management consulting firm.

"A lot of hospitals still view case management as a utilization management function with the responsibility to move people in and out of the hospital as quickly as possible. They are going to have problems until they recognize that they have to do things differently," she says.

Hospitals have been focusing on cutting length of stay but now they are challenged to look at costs for post-acute care, Cesta points out.

"We've always tried to pick the least expensive option for the next level of care, but that needs to change," she says. Case managers need to take the quality of the post-acute providers into account as well as the costs, she adds. For instance, if a patient is likely to be able to manage at home with outpatient rehabilitation, that should be the option the case manager suggests, even if the patient's insurance will pay for a subacute stay.

"It behooves hospitals to know

which provider groups deliver the best value in post-acute care. Cheaper is not necessarily better," Zander says. For instance, case managers and discharge planners need to know which post-acute provider does the best work with orthopedic patients versus oncology patients, and which home care agency has organized specific readmission reduction programs.

The new healthcare arena continues to demand that individual decisions and subsequent plans have to be made with each patient and family/caregiver. In order to continue to provide customization within standardization, hospitals have to have a larger staff of care managers and social workers who have the ability to provide in-depth assessments and form relationships quickly, Zander says.

"They may be in a model that expects them to partner with each other across 30, 60, or 90 days of recovery. Length of time will not matter as much as cost per case across time and place," Zander says.

Case managers have only so much time, and with the focus on length of stay, either discharging patients or utilization review has gotten short shrift when case managers are expected to do both functions, Zander says. "Depending on the payer mix and contracts of specific hospitals, utilization review has become intense. However, utilization of resources will eventually include the relative price of providers at different levels of care. Criteria may become less important than internal systemwide agreements between levels of care," she says.

Zander predicts that people who do utilization review will become more like brokers and cost analysts who determine what the cost is likely to be for 30, 60, and 90 days for a particular patient.

Hospitals should create separate roles and job descriptions for nurses who do utilization review and those who do case management, Mullahy says.

"Years ago, hospitals decided that nurses can do both utilization review and case management. These are very different roles, and I don't think the same nurse can do both effectively. Hospitals need to identify those professionals on the staff who are good at utilization review and those who will make good case managers," she says.

Case managers are going to have to understand what the right resource consumption is for each individual patient and work with physicians to keep the costs in line, Cesta says.

"Practice guidelines can dictate the resource usage for the average patient, but there has to be a way to balance and understand what happened when the case goes over in resource consumption," she says.

Since physicians make the final decision and order post-acute care, she suggests a hospitalwide drive to make physicians aware of the implications of what level of care they order. Analyze the cost per case by physician and point out when a lower level of care might have been just as effective, she suggests. "Physicians respond to data, and this is how to get their attention," she says.

Case management departments are going to need a commitment from their physician leader to take charge of implementing the changes. "Because the doctors are writing the orders, this has to be a physician-led initiative with support from the case managers," she says. ■

Look beyond the discharge and plan patient transitions

Post-acute partnerships are becoming essential

As penalties rise for readmissions, it is critical for hospitals to implement and support continuity of care initiatives as patients transition from one level of care to another, says **Cheri Lattimer**, RN, BSN, executive director of the Case Management Society of America (CMSA), based in Little Rock, AR. "As patients move from the hospital to the skilled nursing facility to home, the role of the case manager becomes extremely important," she says.

Case managers should be doing care transitions, not discharge planning or patient hand-offs, she says. "It's not just a matter of using different terms. It is a seismic shift in how we think," says **Patrice Sminkey**, RN, chief executive officer for the Commission for Case Management Certification, based in Mount Laurel, NY.

"We need to reset the conversation about where case managers are in the continuum. It's not about discharge planning and getting patients out the door. It's about looking at a patient from the point of entry and creating a plan that looks past the hospital and on to the next setting," Sminkey says.

"The time has come for partnerships to improve transitions.

Hospital case managers can't do it alone," says **Karen Zander**, RN, MS, CMAC, FAAN, president and co-owner of the Center for Case Management. She suggests developing a cross-continuum team of case managers and social workers who are focused on specific populations of patients.

The ideal situation would be for the same case manager to coordinate care for patients from admission through the hospital stay and for at least 30 days after discharge, Zander says. "If we want to keep patients from being readmitted within 30 days, the new mindset has to be a deep understanding of each patient's disease or condition and its trajectory over time. It will be imperative for acute care social workers and RN case managers to understand the implications of what brought the patient to the hospital and what needs to happen after discharge — not only level of care but the medications, sequencing of therapy and specialist physician visits, educational goals that are realistic for each patient, community services, and mostly, the support from families and others."

Reducing readmissions is only the tip of the iceberg as far as new expectations for case managers and social workers, she adds.

Case managers need to sit down and get to know their patients in order to create a successful discharge plan, says **Catherine M. Mullahy**, RN, BSN, CCRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY-based case management consulting firm. They have to be able to identify the patients at risk and do something to eliminate the risk, she adds.

"In a lot of hospitals, case managers are doing bits and pieces of the case management process. They're identifying patients at risk and getting them out of the hospital but they aren't doing anything beyond that," Mullahy says.

Case managers need to identify someone at the next level of care who can understand and manage the patient and communicate with them about that patient's condition and situation, she adds.

"The new way of thinking is that the discharge from a hospital is not a final discharge but a transition to home or a post-acute provider. The mindset has to change from concentrating on getting patients out the door as quickly and safely as possible to planning the transition. Case managers have to assess the patients well and evaluate their relative risks of being readmitted. We are all on a huge learning curve about that challenge," Zander says. ■

New responsibilities mean a lower caseload for case managers

Experienced professionals are a must for the job

The Affordable Care Act and other provisions of healthcare reform definitely have shone a bright light on utilization, care coordination, and case management interventions, says **Cheri Lattimer**, RN, BSN, executive director of the Case Management Society of America (CMSA), based in Little Rock, AR.

"But there's more on case managers' plates than ever before," she adds.

One of the issues facing hospital case managers is the short amount of time they have to work with patients and the tasks they are expected to complete, Lattimer points out. "Case managers are being asked to keep tabs on the length of stay, coordinate services the patients receive, create discharge plans, and conduct transitions of care, all in the short time the patient is in the hospital. This is a prescription for disaster," she says.

In many of today's hospitals, case managers, social workers, discharge planners, and other clinicians are spending too much time in the medical record but are not talking to patients and their families, says **Karen Zander**, RN, MS, CMAC, FAAN, president and co-owner of the Center for Case Management, based in Wellesley, MA. "Instead of managing care, they are managing documentation. Among clinicians who really enjoy patient and family contact, there is a great deal of mourning about that situation," she says.

Case managers can't help their hospitals succeed in this new world if they have a caseload of 30 patients; then, they're just putting out fires and not doing enough critical thinking and collaborating with physicians on the best plan for the patient, adds **Toni Cesta**, RN, PhD, FAAN, and partner and consultant in Dallas-based Case Management Concepts.

Hospitals must have adequate

case management staff to deal with all of the additional responsibilities and to do them well, Cesta adds.

But it won't help hospitals to add staff if they just put new case managers on the floor without adequate training, says **Patrice Sminkey**, RN, chief executive officer for the Commission for Case Management Certification, based in Mount Laurel, NJ.

"The industry is going to have to address the need for qualified professionals to be able to meet the new demands or else quality or the care itself may suffer. Case managers need experience, education, and training and should be able to demonstrate that they have the competence and skill set to handle the job," Sminkey says.

And as the healthcare environment changes, it's even more important for professional case managers to be either RNs or social workers who have the experience and background to manage patient care through the continuum, Lattimer says.

Hospitals need to clarify the role of nurses, social workers, and case managers and to make sure each discipline knows its responsibilities, Zander says.

Sminkey suggests sitting down and looking at the job descriptions for each member of the healthcare team and making sure the right individual is in each position.

Analyze the job descriptions to make sure there is no duplication of effort. "So often services fall through the cracks when two people are dealing with one matter and none are working on another," she says.

Identify core competencies that the case manager needs to perform and what outcomes could look like if the right people are doing the job, she says.

In many hospitals, inpatient and outpatient case managers report to different people, which creates silos and makes it difficult to coordinate services patients receive in each setting, Zander says. She suggests that all of the case managers report to the same person to avoid walls between the two points of care.

Case managers are so overloaded that all they have time to do is fill in one window after another on the electronic patient chart, says **Catherine M. Mullahy**, RN, BSN, CCRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY-based case management consulting firm.

"They don't have time to read other people's input to get a complete picture of the patient," she adds.

Mullahy suggests that instead of having case managers assess every patient, the nurse on the unit should screen patients for case management. "Then and only then should case managers get involved. Seeing every patient is a waste of case managers' time," she adds.

She recommends developing an acuity checklist that nurses on the unit can use to help screen for patients who need case management. Social workers should be involved with patients who need community services, she says.

"Social workers and RN case managers should work together on complex patients," she says. In today's healthcare environment, it's going to take a team approach to provide the care patients need and to ensure safe transitions, Mullahy says.

The hospital culture has to change to meet the challenges of a changing healthcare system, Mullahy says.

"It's not going to work until hospitals have a dedicated case management department with specific roles. Physicians see case managers as being in charge of utilization review and not as a working partner," she says.

Technology is going to play a huge role in healthcare's future, but don't let it replace person-to-person communication, Lattimer says. Resources like the health information system can increase efficiency, she says. But if clinicians don't know how to communicate as a team and solve problems together, it will have an impact on patient care, she adds.

Develop a team of licensed and unlicensed staff in your case management department, Lattimer suggests.

"There is a tremendous amount of administrative work and telephone calls that do not require an RN or a social worker. Having a case management extender, who is not a nurse or social worker, will free up the licensed professionals on the team to work at the top of their license and scope of practice," she says.

Case management extenders can be trained to make follow-up calls to find out if patients got their prescriptions filled and if they have any questions and then triage any problems appropriately to a nurse, social worker, or pharmacist, she says.

In the new world of healthcare, hospitals need a highly functioning interdisciplinary team in order to succeed, Sminkey says.

"This is an opportunity to talk about how we can work together better. We need to look at the entire healthcare team as a unit, putting patients in the center and optimizing each function for better care, better quality, and better cost," Sminkey says. ■

Navigator reduces readmissions, inappropriate ED visits

Pilot project paid for itself

When Lakewood Hospital in the Cleveland Clinic Health System brought on board a patient navigator to guide patients through the healthcare maze, the hospital saved $156,000 in just six months.

"The navigator's interventions generated significant savings, covering the entire cost of the project in the first three months of the pilot program. In 2013, the navigator worked with 1,500 patients and only 3.16% were readmitted," says **Sarah Fay**, MBA, director of operations for The Center for Health Affairs, which worked with Lakewood Hospital and Accenture on a pilot program. Lakewood Hospital Foundation provided nearly 85% of the navigator's salary during the pilot phase, with the Harold P. Freeman Patient Navigation Institute providing a grant for the balance, according to **Mary McLaughlin Davis**, DNP, MSN, ACNS-BC, CCM, director of case management for the hospital.

"The pilot was so successful that the hospital continued the program for another year with renewed funding from Lakewood Hospital Foundation and now in the third year, fully funds it," McLaughlin Davis says.

The pilot focused on reducing Medicare 30-day readmissions and reducing the number of self-pay patients who visit the emergency department for non-emergent care.

Patients in the pilot program who worked with the navigator experienced a 30-day readmission rate that was 4% lower than other patients, which saved the hospital a minimum of $29,702, according to Fay. Self-pay patients had 5% fewer revisits to the emergency department for a savings of $127,102.

"These patients were misusing resources because they didn't understand where they should go for care. The navigator educated them that instead of going to the emergency department, they should go to an urgent care center for treatment when their doctor's office is closed," she says.

Before the project began, a team from The Center for Health Affairs and Lakewood Hospital did an assessment within the hospital emergency department to determine where patients were falling through the cracks and what services a navigator should provide, Davis says.

"Our biggest challenge was trying to determine how to measure success. We are one of the smaller community hospitals and we don't have an identifiable large high-risk group. We knew intuitively and experientially that many patients who came into the emergency department would come back again and again. The one common thread was that they didn't have a primary care provider," Davis says.

Getting patients connected to a primary care provider was challenging because many of the patients didn't have insurance and they didn't understand the importance of having a primary care provider, she says. In some cases, patients' primary care providers had retired and they had not established a relationship with another physician, Davis says.

The problem was compounded by the limited number of community physicians for self-pay patients and Medicaid beneficiaries. Often, lack of transportation to the physician office was a barrier, Fay adds.

The pilot's goals were to reduce the number of 30-day readmissions and self-pay visits in a 30-day period by identifying barriers to care for the hospital's population and developing strategies to eliminate them.

"We wanted to look at how a patient navigator would impact the patient experience and the bottom line for the hospital. The pilot proved

EXECUTIVE SUMMARY

Lakewood Hospital's pilot project in which a patient navigator worked with at-risk patients saved the hospital $156,000 in just six months.

- The goal of the program was to reduce the number of 30-day readmissions and self-pay visits in a 30-day period by identifying barriers to care.
- The navigator helps the self-pay patients find a medical home at low-cost clinics or federally qualified health centers and helps other patients identify a primary care physician and set up a follow-up appointment. She rounds with the treatment team and collaborates on discharge plans.
- In the first year of the program, the navigator worked with 1,500 patients and secured more than 1,000 follow-up appointments before discharge.

The New Value-Based Purchasing Efficiency Measure: Are You Ready?

By Toni Cesta, PhD, RN, FAAN

Introduction

As one of the elements of health care reform, the Centers for Medicare & Medicaid Services (CMS) has implemented a course of action aimed at bringing Medicare to a break-even budget. The elements that we are now familiar with include the "clinical processes of care," "outcomes" (which include readmissions, deaths and complications), "the patient experience of care," and the "efficiency measure." This month, we will focus on the efficiency measure as it so closely complements the work of case managers in the hospital setting. Of course, case managers must also participate in the other value-based purchasing initiatives. We have a role to play in coordinating the clinical processes of care, or core measures, and readmissions. We also participate in improving the patient experience of care and have a lighter role in reducing deaths and complications.

However, the efficiency measure brings much of the work of case management to the surface yet again. This measure focuses on length of stay and spending per beneficiary episode, two elements that case management plays a critical role in controlling and managing.

CASE MANAGERS "HAVE A ROLE TO PLAY IN COORDINATING THE CLINICAL PROCESSES OF CARE."

Definition of the Efficiency Measure

Medicare's purpose in applying this measure is to encourage hospitals to be more cost-efficient by providing financial incentives to hospitals based on their performance. CMS also hopes to increase the transparency of care for consumers and recognize hospitals that are involved in providing high-quality care at lower cost.

This claims-based measure assesses the beneficiary's Part A and Part B spending during an "episode." For the purposes of this measure, an episode spans from the three days prior to a hospital admission through 30 days after patient discharge. It includes transfers, readmissions and additional admissions during this 30-day period. The measure is adjusted for age and severity of illness. It is also price-standardized. Price standardization removes any variation that may be due to differences in wages based on geographic location, as well as other factors such as indirect medical education payments (IME) or disproportionate share hospital (DSH) payments. Risk adjustment accounts for variation due to the patient's health status.

According to CMS, "Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Certain conditions must be met to get these benefits." *(http://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/Part-A.html.)*

As for Part B, according to CMS, "Medicare Part B (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary." *(http://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/Part-B.html.)*

Achievement Versus Improvement Scores

The achievement threshold for hospitals is set

by CMS as the median Medicare spending per beneficiary across all hospitals during the performance period. It is your hospital's performance compared to all other hospitals. Hospitals with a score above the achievement threshold will receive zero points. Those with a score at or below the achievement benchmark will receive ten points. All other hospitals will receive 1 to 9 points.

The improvement score is your own hospital's performance as compared to its own performance during the baseline period. Hospitals with a score equal to or higher than baseline would score 0 improvement points. Hospitals with scores at or below the improvement benchmark would receive 10 points. All others would receive 1 to 9 points.

Case Managers Should Know their Own Efficiency Score

The efficiency score measure shows whether Medicare spends more, less, or about the same per Medicare patient treated in your hospital as compared to other hospitals across the United States. Factored in are Part A and B expenses for the three days prior to the admission through thirty days post-discharge, resulting in a ratio. The ratio is calculated by dividing the amount Medicare spends per patient for an episode of care initiated at your hospital by the amount spent per patient nationally. A ratio equal to the national average means that Medicare spends about the same per patient for an episode of care at your hospital as it does at the average hospital nationally. Higher ratios mean more spent than the average, and lower ratios mean less spent. So for this measure, less is more!

You can use this understanding of the measure to look your own hospital's score up on the website www.hospitalcompare.hhs.gov.

Care Provided Across the Continuum Affects the Score at Your Hospital

As you review your hospital's score, you must keep in mind how you, as a case manager, can impact this score. First of all, any provider along the continuum of care will have an impact on the score. Care provided to the patient within seventy-two hours of admission resulting in a Part A or Part B bill will be calculated in. So for patients receiving care by a primary care doctor, or diagnostic testing in the outpatient setting, these costs will be included. Conversely, for patients receiving post-acute care such as home care, or care in a skilled nursing facility or rehab setting, these costs will also be included.

Case managers in the emergency department can have an impact on cost containment by alerting the emergency room doctor to any tests that were just done in the outpatient setting. Traditionally, the emergency room physician will repeat these tests. Because of the new efficiency measure, this practice will need to change. These redundant costs will increase the hospital's score. In addition, it is simply not good practice to re-expose patients to tests they do not need to have repeated.

The same should apply to patients continuing to receive care in skilled nursing facilities or rehab centers. The facility can obtain all prior tests and should be as conservative as possible when considering repeating them. In your role as discharge planner, you should be sure to send as much of this information along with the patient as is appropriate. Today, much of this hand-off information can be sent electronically.

Managing Cost Through Care Coordination

Care coordination is the primary role case managers perform that directly affects length of stay and cost. While utilization management and timely discharge planning also have an impact, care coordination affects the care progression of the patient through the acute care episode. We can define care coordination as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care in order to facilitate the appropriate delivery of patient care services."

Care coordination is an active process. It involves the marshaling of personnel and other resources needed to carry out all the required patient care activities. It is often managed by the exchange of information among participants responsible for different aspects of care. But it is also an active process that case managers must use to ensure that patient care is delivered appropriately and timely. The care must first be coordinated and then must be facilitated. Facilitation involves the removal of any barriers to timely care

progression and requires a daily review of the patient's care needs and identification of any delays in meeting those needs.

Managing patient flow can be an important tool in the case manager's toolbox for care coordination. Elements to focus on include:

- delays in inpatient services, including ancillary services such as radiology;
- delays in accessing community resources;
- payer delays;
- timeliness of test results reporting;
- physician care progression delays;
- family decision-making delays.

These elements are referred to as avoidable days, avoidable delays or variances. Case managers, as part of the care coordination process, must identify and correct these types of barriers to patient flow as they occur.

Length of Stay and Cost of Care

While length of stay and cost of care are related, they do have to be addressed as separate issues. If length of stay is reduced, yet all the direct costs of care remain the same, then not much is saved. Therefore, any length of stay reduction program must also address the quantity of resources consumed, for the day and for the entire stay, as part of the improvement plan. Direct costs of care include items such as laboratory, radiology and pharmacy services. Indirect costs are items such as lighting, heat and air conditioning, insurance, and so on. These are typically fixed costs that do not vary but rather are spent whether or not a patient is occupying a bed.

Cost reduction must be aimed at the direct costs associated with the patient's stay and should be geared around a set of best practice guidelines that outline the average cost to care for a specific type of patient. Many hospitals have moved toward standard order sets and practice guidelines to help drive practice change as it relates to care progression, resource consumption, and outcomes of care.

It is still common for physicians to not have access to their own cost data, and certainly many case managers do not have this type of access. Today's challenge is to develop a way to bring the cost data (including length of stay) together with the clinical data in a way that is meaningful and useful. As hospitals begin to develop these types of report cards, case managers will be able to work with them to identify "real" strategies for managing cost and length of stay. Electronic medical records are a vital component of this and provide access to data in ways that were not readily available in the past.

If you are developing such a report, be sure to include only cost data that is impacted by the physician. Provide information as to how the cost data was obtained to improve its credibility. Determine just how detailed you want to get. There is a fine line between giving relevant information and overwhelming the reader with details. As mentioned above, report the direct costs associated with what the physician ordered for the patient and that were within his control.

Length of Stay Strategies

Case managers have had responsibility for length of stay management since the specialty moved into the acute care setting in the late 1980s. Today, length of stay is a more difficult outcome to manage, as the margin for improvement is usually so small. In addition, length of stay management must be an interdisciplinary process of improvement that involves all members of the team.

You may want to start off with an analysis of your top diagnoses by volume, and then cross-walk these against the diagnoses that are most predictable and/or manageable. The most commonly seen diagnoses today include heart failure, pneumonia and major joint replacements. Sepsis and renal failure are also commonly seen, and any of these may represent opportunities in your hospital. Start with those that represent the greatest opportunity in terms of length of stay reduction and volume. You may have a few diagnoses with a large number of excess days, but these may be in small volume. Once you have identified the diagnoses you want to focus on, you should select teams to work on them. If possible, have each team chaired by a physician who specializes in the diagnosis you are working on. This will lend clinical credibility to the team, but also ensure that the physicians feel part of the process.

When working with physicians on length of stay reduction programs, I recommend that you start with an analysis of the data surrounding that diagnosis or

surgical procedure.

Begin to understand the issues surrounding that diagnosis such as:

- volume;
- average length of stay;
- cost per day;
- cost per stay;
- top admitting physicians;
- avoidable delay reasons;
- discharge destinations;
- readmission rate and causes of readmission;
- third-party payer denials of payment;
- RAC or other auditor denials;
- typical levels of care such as observation versus inpatient;
- observation to inpatient conversion rate.

By collecting this data, you will have both a baseline and an idea as to where to focus the team's efforts.

Other elements that affect cost and length of stay should also be examined as you take a deep-dive look at the diagnosis:

- preventable readmissions;
- health care-associated infections;
- adverse drug events;
- unwanted end-of-life services;
- unrelated diagnostic tests;
- delayed test results;
- delayed scheduling.

You may want to create a diagnosis-specific report card that includes a selection of the elements listed above. If possible, include the percentage of impact that each issue has on the overall length of stay for that diagnosis or surgical procedure. A Pareto chart is a good tool for looking at the data as well. You can use this type of chart to help the team focus on the issues representing the greatest opportunity for improvement. Physicians will respond positively to data that is clearly understood and objective.

As case managers, we must focus on length of stay management and strategies for continuous reduction. However, if we reduce length of stay and the cost of care remains the same, then the overall impact on the bottom line of the organization will be greatly reduced.

> "AS CASE MANAGERS, WE MUST FOCUS ON LENGTH OF STAY MANAGEMENT AND STRATEGIES FOR CONTINUOUS REDUCTION."

The goal in managing cost in order to impact the efficiency measure would be to reduce the use of unnecessary tests, treatments and procedures while also reducing delays in providing these services. This is an important core role of the hospital-based case manager and one that is often overlooked due to inadequate staffing ratios, lack of focus on this issue, or a case management model that does not include this as a core function in the role of the case manager in that hospital.

In best practice models today, the case manager must have clinical competence and experience in order to work with the physician who is managing the patient's care. The case manager can be responsible for

- setting milestones of care with the physician, liaison with the family;
- facilitating care plans with physicians, nursing and ancillary departments;
- identifying the expected length of stay;
- focusing the team on evidence-based practice;
- monitoring clinical and financial outcomes throughout the stay and at the point of discharge;
- consistently tracking and managing avoidable delays;
- facilitating timely transitions.

Summary

The CMS efficiency measure has once again raised the issues of length of stay management and cost reduction. These have always been a component of the role of the hospital-based case manager. In today's best practice models, these interventions must be correlated with the roles of coordination and facilitation of care, discharge planning and utilization management. The case manager's roles and functions, as well as staffing ratios, must be designed in such a way as to allow for this integration of roles. Be sure that your department is focusing on how to embed this important function in your everyday practice! ■

that the benefits of having a navigator far outweigh the costs," she says.

The team hired **Jessica Roberts** to work as a full-time lay navigator. Roberts is stationed in the emergency department and reports to the case management department. "Her hours are based on the needs of the department. We looked at the highest volume, coupled with the follow-up appointment times and decided to focus in that time frame," Fay says.

Roberts works with patients who are admitted through the emergency department and patients who are not admitted but who do not have a primary care physician. She estimates that she sees about 95% of her patients in person. "Sometimes I receive referrals from the emergency department or surgery to work with patients who are not admitted but who need assistance," she says.

She sees some patients only once but works with many of them over time.

"I've been working with some patients since the beginning and have developed a relationship with them. If they experience problems with transportation or are confused about how to navigate the healthcare system, they contact me for help," Roberts says.

Roberts starts her day reviewing a list of all patients who were admitted, then goes on interdisciplinary rounds on units that have admitted patients overnight. "All the case managers know me and bring patients who might need more assistance to my attention," she says.

When patients are admitted, Roberts focuses on those who were admitted without a primary care physician. She meets the patients during rounds, then visits them later to discuss their discharge and help facilitate follow-up appointments. During the conversations, she often identifies barriers to care such as lack of childcare or inability to pay for medication and helps connect them with community resources.

"Many of the self-pay patients who are not admitted come in with non-emergent issues. Many do not have a primary care physician or they don't understand how to utilize the healthcare system," Fay says.

Roberts helps self-pay patients find a medical home at a federally qualified health center or another low-cost clinic and facilitates a follow-up appointment. She helps them sign up for medication assistance, transportation assistance, and other community resources. She helps schedule orthopedic follow-up appointments for patients in the emergency department.

"I call patients the day before their appointments to remind them and make sure they have transportation," Robert says. She follows up to make sure they went to the appointment and to find out if they need any other assistance. She asks a series of general questions and, if the patient has questions or concerns, she can refer them to a member of the care team for follow up.

Roberts collaborates with the case managers and social workers on the unit and relieves them of duties that don't need a license, such as scheduling transportation and setting up medication assistance. "The case managers and social workers feel less overloaded and are able to work at the top of their license with Jessica to support them," Fay says.

In the first year of the program, Roberts secured more than 1,000 follow-up appointments before discharge. The majority of those patients did not have a primary care practitioner.

"The greatest success of this program is giving our patients the ability to manage their own healthcare. And the hospital has been able to reallocate resources and caregivers to focus on other important aspects of patient care," Davis says. ■

Hospitalwide initiative decreases readmissions, length-of-stay

Projects rolled out every quarter

Recognizing that case management alone can't ensure smooth transitions in care, OSF Saint Francis Medical Center in Peoria, IL, developed a series of initiatives to engage the entire hospital staff as well as attending physicians in the importance of safely transitioning patients across the continuum.

As a result of the initiatives, the hospital achieved a decrease in the 30-day all-cause readmission rate and a significant reduction in length of stay, says **Jane Counterman**, RN, manager of care management.

"It took a culture change to implement this program. As a department, case management changed first, but we knew it couldn't end there. We can do

our best to create safe transitions, but it won't work as well unless the administration is on board and bedside nursing, providers and everybody else on the team are engaged," Counterman says. For what it calls its Best Care initiative, the hospital put together a multidisciplinary team to develop a series of projects aimed at improving transitions.

"We didn't just want to throw a lot of new ideas at the frontline staff and expect it to make sense. Instead, we developed an infrastructure and a plan to roll out a new initiative every quarter," says **Leslie Foti**, supervisor of transitions and outcomes.

The team initially focused on reducing readmissions and piloted Project BOOST on two units. Every nurse and every case manager went through four hours of classroom training and simulations on navigation and other readmission prevention strategies and how to engage with physicians, pharmacists, and ancillary department staff. For two weeks, a supervisor supported them on the unit to help them navigate.

Project BOOST lists 8 P's that indicate a patient is at risk for readmission. They are: presentation of the patient, problem medications, psychological, principal diagnosis, polypharmacy, poor health literacy, patient support, and prior hospitalization. The OSF Saint Francis team added a ninth predictor: the need for palliative care.

The bedside RN assesses patients for risk of readmission, using Project BOOST guidelines within four hours of admission. Then the bedside nurse on every shift reviews and updates the assessment. If the patient meets any of the risk factors, the electronic medical record has a check-off box that triggers an alert to the appropriate care team member for an intervention. For instance, if the patient has polypharmacy issues, the alert goes to a pharmacist. If the patient needs financial assistance, social work is alerted.

"After the initial assessment, the subsequent shifts review the patient to make sure there are no new risks. We know that things can happen through the hospital stay to make risk factors go from negative to positive, and we didn't want anything to fall through the cracks," Foti says.

In another initiative, the Care Partner Program, patients are asked to choose a partner to be engaged in their care. Participation in the program is voluntary. The hospital gives each patient's partner a wrist band that identifies him or her, offers the partner employee discounts in the cafeteria, and involves him or her in the day-to-day care for the patient.

"We engage this person in caring for the patient from Day 1. The Care Partner may take the patient for a walk or learn to change the dressing. This doesn't take the place of nursing but enhances the patient experience and helps the caregiver learn to care for the patient after discharge," Counterman says.

To reduce the risk of readmission because patients don't get their prescriptions filled, the hospital partnered with an onsite commercial pharmacy to bring medications to the bedside. "This program enhances the patient experience, prevents readmissions, and results in a financial gain for the commercial pharmacy," Foti says.

The team on every shift assesses patients for delirium using the Confusion Assessment Method. If the patient is positive, it prompts a set of interventions that includes a consultation from the pharmacist to review medications and a phone call to notify the patient's physician of the change.

Each day, the multidisciplinary treatment team develops SMART (Specific, Measurable, Attainable, Realistic, Timely) goals for each patient and enters them on the SMART board in the patient room. "We make sure the goals are legible and that the patients understand

EXECUTIVE SUMMARY

As part of its efforts to decrease readmissions, OSF Saint Francis Medical Center in Peoria, IL, developed a hospitalwide initiative to create safe transitions.

- The bedside RN assesses patients for risk of readmission, using Project BOOST guidelines, within four hours of admission, and the nurse on every shift repeats the assessment.
- The team on every shift assesses patients for delirium, and when patients test positive, initiates a series of interventions including a referral to a pharmacist to review medication and notifying the patient's physician.
- Nursing and case management use a discharge readiness report, a checklist of discharge needs, to make sure everything needed for the discharge is in place.

what they are to do that day," she says.

The team instituted the teach-back method for patient education. Whoever does the teaching documents it in the patient record.

All patient care managers round every day on every patient, ask a standard set of questions, and feed the answers into a dashboard that is available to the entire hospital. For instance, they ask: Do you have a care partner? Were you told about the medication to bedside program? Do you have a goal?

The team created a discharge readiness report, a discharge needs checklist that is filled out by nursing and case management. "It's an easy way for the team to look quickly and double-check that all of the items on the list have been done," Foti says.

A key to the success of the Best Care initiative is real time measurement and daily, weekly, and monthly dashboards that show how compliant the staff are with the components of the initiative, Counterman says. The data is on a spreadsheet and can be drilled down to the patient level and how individual staff members are performing on the metrics. If one unit is struggling on a measure, the manager can call on the manager of a unit that is more successful to see what that unit is doing.

"Now the entire hospital is focused on care transitions and the providers understand how the decisions they make affect outcomes. Everybody speaks the same language and understands what the goals are, and that makes a huge difference," she says. ■

Antibiotic stewardship reduces pediatric patients' length of stay, readmissions

Stopping antibiotics, discharging sooner worked

Hospitalized children were discharged sooner and were less likely to be readmitted when physicians followed the recommendations of an antibiotic stewardship program, researchers reported recently in Philadelphia at the IDWeek 2014 conference. The study is the first to show the benefits of drug stewardship on children's health.

"Studies have shown stewardship programs reduce antibiotic use and decrease the risk of resistance, but this is the first to demonstrate that these programs actually reduce length of stay and readmission in children," said **Jason Newland**, MD, lead author of the study and medical director of patient safety and systems reliability at Children's Mercy Hospital-Kansas City, MO.

Based on the findings of benefit to pediatric patients, Newland recommended other hospitals implement such programs and invest the resources to support them.

Over the course of the five-year study, the antibiotic stewardship program recommended that the prescribed antibiotic be discontinued or the dose or type of antibiotic be changed in 1,191 (17%) of 7,051 hospitalized children reviewed by the program. The child's physician had the option of accepting or rejecting the recommendation.

When the program's recommendations were followed, the length of stay was shorter, and 30-day admissions were reduced among children who did not have complex chronic care issues, such as cerebral palsy or congenital heart disease, he said.

The length of stay averaged 68 hours and there were no 30-day readmissions among children whose doctor followed the recommendation, while the length of stay averaged 82 hours and 3.5% were readmitted within 30 days among those whose doctor did not follow the recommendation.

The most common recommendation was to discontinue the antibiotic because the stewardship program determined it wasn't necessary. Those who continued the antibiotic remained in the hospital so they could be monitored.

"Skeptics say stopping the antibiotics and sending the kids home sooner will lead to more children being readmitted, but we didn't find that," Newland said. "What we found was that kids were being taken off unnecessary antibiotics sooner — and in a safe manner." ■

Better handoffs improve safety at children's hospitals

Pediatric patients might be at particular risk

Eliminating distractions and standardizing the process for patient handoffs has helped a group of children's hospitals reduce handoff errors by 69%.

Patient handoffs are increasingly recognized as potential threats to patient safety, and critically ill children might be even more at risk than other patients, says pediatric critical care doctor **Michael Bigham**, MD, at Akron (OH) Children's Hospital. Responsibility for critically ill children is frequently transferred from one clinician or unit to another, he notes. Because of their ages, pediatric patients might be affected more by errors that occur with the handoff.

Bigham has studied how to improve patient handoffs for six years. He led the team that recently published a yearlong study, "Decreasing handoff-related care failures in children's hospitals," which involved 23 children's hospitals across the country. The researchers examined 7,864 patient handoffs and the effect of implementing standardized procedures to reduce miscommunication and care failures during the handoff process. The study did not directly measure patient harm, but rather a predicate marker of harm. *(See the story on page 175 for more on the study.)*

A major safety concern

Patient handoffs have been identified as a major patient safety concern by major healthcare organizations, including The Joint Commission (TJC), the World Health Organization (WHO), and the Institute of Medicine (IOM). In 2006, The Joint Commission required accredited hospitals to implement a standardized handoff process, and in 2007, the WHO highlighted the role standardized processes had in reducing handoff-related errors. In 2008, the IOM recommended focusing on handoff processes to improve patient safety.

"The Joint Commission has looked at a decades' worth of sentinel events between 1995 and 2005, and breakdown in communication was the leading root cause of sentinel events in that period of time," Bigham says. "The IOM also has stated that inadequate handoffs are where the safety process fails first. Handoff failures are a huge risk to patient safety."

With years of emphasis on improving patient handoffs, Bigham and his colleagues realized that among children's hospitals, handoffs were the poorest performing safety domain. Early in the study research, Bigham and others investigated the baseline rate of handoff failure at the hospitals. Selecting patient handoffs at random, they interviewed the receiving patient care team about whether they had encountered any care failures as a result of inaccurate or missing information at the handoff.

Patient safety leaders from the hospitals studied their data on patient handoffs and also developed a "change package" that explains the components necessary to improve the process. The researchers developed these four key steps:

- Define the handoff intent.
- Define the handoff content.
- Define the handoff process.
- Combine all of those in a way that maximizes teamwork.

The hospital leaders recognized early on that there would be no single way to roadmap the handoff procedure that would work for every hospital. Instead, each hospital identified the pertinent handoff scenarios in their facilities, applied those steps to their own facilities, and developed their own improvements. As a result of process improvements flowing from the research, the participating hospitals decreased handoff-related failures by 69% during the study.

"The solutions developed at the different hospitals were shared with the other participants, so people could pick and choose the parts they liked and apply them to their own settings," Bigham says. "At the end of a one-year cycle, all 23 hospitals had either moderate-scale or large-scale implementation of improvements involving one or more different types of handoffs."

When the research team compared the handoff failure rates at the end of the study, they found that the hospitals had reduced the rate of failures by 69%.

"We were confident that by the end of this process, our patients were safer and subject to far

fewer patient care problems from miscommunication at handoffs," Bigham says.

Though the improvement plans were specific to each hospital, all of them followed the four key steps.

Reducing distractions

Akron Children's examined three types of handoffs and saw a 36% reduction in handoff-related failures. The handoff scenarios included:

- The transition of patient care responsibility during shift change for nurses, such as night shift to day shift and vice versa.
- The patient's transition from the emergency department to inpatient.
- The temporary transition of an inpatient to and from radiology.

Akron Children's implemented a standard procedure for handoffs designed to eliminate distractions during the handoff process and result in a clear transition of responsibility from caregiver to caregiver, explains Quality Director **Cathy Gustaevel**, who also is responsible for patient safety. Many of the changes encourage face-to-face interactions, rather than leaving notes for other caregivers, Gustaevel explains.

"I think the impact is going to be huge. The improved process is going to give us some consistency and reliability that what happens in the emergency room as far as handoffs is the same as what happens in critical care," Gustaevel says. "This will increase the safety of the kids because standardization often reduces or eliminates errors. Everyone here knows that the person on the other side of the handoff will do it the same way you've been trained, and they will do it that way every single time."

Some clinicians resisted the handoff improvements at first but warmed to the idea as they saw how the standardized procedure reduced errors, Gustaevel says. Children's Hospital also involves parents in the handoff procedure, with the theory being that they know everything about their child far better than anyone else. The parents listen in and are encouraged to add their own comments or to question the handoff information.

But are the practices developed in the course of the children's hospital study any different from what hospitals already have been trying?

"I'm not sure hospitals have really been trying to improve handoffs. Either hospitals have not improved their processes or what they tried is not working," Bigham says. "This concept of patient handoffs cannot be ignored any longer. Patient handoffs should be just as important to patient safety as the surgical procedure itself and the right settings on the ventilator." ■

1 in 4 handoffs threaten patient safety

Study authors: Standardized, evidence-based process can reduce handoff-related care failures

The researchers who studied patient handoffs at 23 children's hospitals found an alarmingly high baseline rate of handoff failure: 25.8% of the handoffs were insufficient or inaccurate.

Twenty-three children's hospitals evaluated 7,864 handoffs over the study period, which was 12 months. *(For more information about the study, see http://tinyurl.com/m56avmq.)*

In the final intervention period, handoff-related care failures decreased from the baseline 25.8% to 7.9%. Significant improvement was observed in every handoff type that was studied. The changes raised the common understanding about the patient from 86% to 96%, having a clear transition of responsibility rose from 92% to 96%, and minimizing interruptions and distractions increased from 84% to 90%.

Overall satisfaction with the handoff went from 55% to 70%. The study's authors made the conclusion that the implementation of a standardized evidence-based handoff process can result in a significant decrease in handoff-related care failures, observed across all types of handoffs. ■

COMING IN FUTURE MONTHS

- Innovative strategies to cut readmissions.
- Marketing case management to the C-suite.
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CNE QUESTIONS

1. In fiscal 2014, the Centers for Medicare & Medicaid's Value-based Purchasing Program bases what percentage of hospitals' scores on outcomes and efficiency?

A. 20%
B. 30%
C. 50%
D. 60%

2. According to Toni Cesta, RN, PhD, FAAN, partner and consultant for Case Management Concepts, case managers can't do all the tasks they need to do to help their hospitals succeed under healthcare reform with a caseload of 30 patients.

A. True
B. False

3. Before Lakewood Hospital began a patient navigator pilot project, a team from the hospital and The Center for Health Affairs and Lakewood Hospital did an assessment within the hospital emergency department to determine where the navigator should focus. What did they find was the common thread among patients who were frequent users of the emergency department?

A. They didn't have a primary care physician.
B. They didn't have transportation to another treatment site.
C. They didn't understand how to access the appropriate level of care.
D. All of the above.

4. As part of OSF St. Francis Medical Center's efforts to ensure smooth transitions, the bedside nurse assesses patients for risk of readmission, using Project BOOST guidelines within what time frame?

A. Within 24 hours of admission.
B. As soon as the patient gets to the unit.
C. 24 hours before the anticipated discharge.
D. Within four hours of admission.

CNE OBJECTIVES

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

1. identify the particular clinical, administrative or regulatory issues related to the profession of case management
2. 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
3. discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

Hospital Case Management

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