HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Hospitals are still struggling with reducing readmissions

Look to community, caregivers for the solution

Hospitals have been working to reduce readmissions for years, but in the third year of the penalty phase of the Centers for Medicare & Medicaid Services' readmission reduction program, more hospitals than ever before are losing reimbursement for having more 30-day readmissions than their peers.

According to an analysis by Kaiser Health News (http://kaiserhealthnews.org/news/medicare-readmissions-penalties-2015/), a record 2,610 hospitals are being fined a total of $428 million for excess 30-day readmissions for myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, and total knee and hip arthroplasty.

Beginning Oct. 1, 2014, hospitals with more readmissions than their peers could lose up to 3% of reimbursement for every Medicare admission.

And that's not the only reason hospitals have to get a handle on readmissions, says **Brian Pisarsky**, RN, MHA, ACM, senior

READMISSIONS: THE HITS JUST KEEP COMING

Despite their best efforts to keep patients from coming back after discharge, hospitals continue to lose reimbursement — up to 3% of their Medicare payments as of Oct. 1, 2014. In this issue, we'll ask the experts what hospitals should be doing to ensure safe transitions. We'll include information on why total joint replacement patients come back, tips from a home health provider, and how a patient's functional status can indicate the potential for readmission. You'll learn how one health system cut its all-cause readmission rate by 20% and how another is partnering with the local Agency on Aging to follow up with at-risk patients. It's all in this issue of *Hospital Case Management.*

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EDITORIAL E-MAIL ADDRESS:
leslie.hamlin@ahcmedia.com.

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EDITOR: Mary Booth Thomas, (marybootht@aol.com.
EXECUTIVE EDITOR: Russ Underwood (404) 262-5521 (russ.underwood@ahcmedia.com).
ASSOCIATE MANAGING EDITOR: Jill Drachenberg
EDITORIAL & CONTINUING EDUCATION DIRECTOR: Lee Landenberger

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

managing consultant at Berkeley Research Group and Centers for Medicare & Medicaid Services (CMS) alumni faculty for the Community-based Care Transitions Program (CCTP).

"A lot of insurance companies have jumped on the bandwagon and developed their own programs for penalizing hospitals for excess readmissions," he says.

While a lot of facilities are dedicating people and other resources to the issue of readmissions, they aren't necessarily getting to the root of the problem, says **Cheri Bankston**, RN, MSN, director of clinical advisory services at Curaspan Health Group, with headquarters in Newton, MA.

"We are just beginning to understand that a lot of what affects readmissions happens outside the four walls of the hospital," Bankston says.

Patients are non-compliant, they don't get their prescriptions filled, often because they can't afford to, or they miss their follow-up appointments because they don't have transportation, Bankston says.

"With more and more hospitals using hospitalists, a lot of information gets lost. Even if patients do show up for their follow-up appointment, their primary care physician doesn't know what happened in the hospital or what follow-up tests or procedures the patient needs," she says.

Case managers and hospitals can no longer shut their eyes to what happens after patients leave the facility, Pisarsky says. "We have to look at patients throughout the continuum, which includes their homes. It is imperative that hospitals communicate better with post-acute providers so they're aware of all of the patient's conditions and comorbidities," he adds.

Handoffs are critical between hospital case managers and those at the next level of care, says **Patricia Hines**, RN, PhD, an independent healthcare consultant based in Los Angeles.

"Hospitals are still struggling to create a seamless flow as patients transition between levels of care, but pieces of information are still getting lost. We need to continue to work on developing good connections between the acute care facility, the physician offices, and other post-acute providers, and community resources," Hines says.

She recommends sending a written report as well as talking to a clinician at the skilled nursing facility, long-term acute care hospital, or home health agency

EXECUTIVE SUMMARY

More hospitals than ever before are being penalized by the Centers for Medicare & Medicaid Services for excess readmissions and insurers are starting to develop their own readmission reduction programs. According to experts:

- Case managers and hospitals have to look beyond the hospital walls and determine what happens to patients throughout the continuum.
- Improving communication with post-acute providers is a critical part of reducing readmissions.
- Recognize that family members or other caregivers are an important factor in a patient's success after discharge and involve them in creating the discharge plan.

to make sure they have a good understanding of the patient's condition and current needs.

Hines tells of situations when a nurse from the acute care hospital has accompanied patients with complex care needs who have been in the hospital for months and are being transferred to a skilled nursing facility. "This is only in extreme situations, but the staff at the receiving facility can get firsthand the information they need and it gives the family a comfort level that the treatment plan is going to be continued in the next level of care," she says.

"When my company, the Berkeley Research Group, consults with hospitals, its experts suggest enhanced collaboration with post-acute providers to find out what information is needed when patients transfer," Pisarsky says. "One of the first steps is developing an explicit form so the information is consistent and in the same order no matter who fills it out and which post-acute provider the patient chooses."

Make sure your discharge information and other communication with post-acute providers includes an updated medication administration record. "There could be readmissions when patients miss a dose of medication or accidentally get it twice," he says.

Some patients refuse home care or a nursing home admission, which makes them at significant risk for hospital readmission, Pisarsky says. "They have a right to make a bad decision but that doesn't mean you give up. Do everything you can to help them stay safe in the community and make sure they have contact information for post-acute providers if they change their minds," he says.

When Holzer Health System began meeting with representatives of the area skilled nursing facilities, home health agencies, and assisted living centers, the facilities asked for a warm hand-off between the hospital case manager and the charge nurse when patients transfer, says **Teresa Remy-Detty**, DSC, MHA, LNHA, BSN, RN, vice president of post-acute care services for Holzer Health System, based in Gallipolis, OH. *(For details on the health system's readmission reduction initiatives, see related article on page 7.)*

"Most of the time, any discussion that takes place is between the hospital care management team and the receiving provider's admissions people," she says. "They requested that the care management team or the discharging nurse at the hospital also call the nurse at the facility when the patient is on the way. The hospital team can give the nurse a full picture of the patient's condition and needs. In addition, the nurse at the facility can tell the patient she talked to the patient's nurse in the hospital. It makes the patient and family feel much more comfortable."

Develop a relationship with case managers in the community, since that's where many problems that cause readmissions arise, advises **Kathleen Miodonski**, RN, BSN, CMAC, vice president of clinical operations for Post-Acute Network Solutions, a company that contracts with managed care organizations to provide care coordination for residents in supportive living facilities, also called assisted living centers.

Patients are in the hospital only a short period of time. The success of their recovery depends on what goes on in the community. That's why case managers need to pass the baton to someone in the next level of care, Miodonski says.

"We feel like we never get enough information about what happened in the hospital. Some of the things we need to know are what treatments were performed and why, results of diagnostic procedures and labs, why changes were made to the treatment regimen," she says.

Being patient-centered isn't enough. Hospitals also have to be family-centered, adds Remy-Detty. "Caregivers are an important part of patients' success in recovering after discharge. The family has to be involved in the discharge planning, and discharge teaching," she says.

Spend time with the patients and family members to get an understanding of patient characteristics, such as culture, language barriers, healthcare literacy, socioeconomic status, and access to social support, and take them into consideration when developing a discharge plan, creating materials for the patient to take home, and educating the patient and family, Hines suggests.

Case managers need to engage the patient and family and help them to see their roles and responsibilities after discharge, she says.

If the patient doesn't have immediate family or other support, look for other resources, such as community agencies, neighbors, and churches, Bankston adds. "Case managers have got to be creative and connect patients with resources before they leave," she says.

Understand all the disease processes the patients are dealing with, not just the ones that brought them to the hospital, she adds.

Develop a discharge plan that the

patient agrees to, and make sure that the patient has the means and the support system to be successful with the plan.

One of the most important pieces is to make sure patients have a way to get their prescriptions and that they fill them and take them as directed, Pisarsky says.

Follow-up telephone calls after patients are discharged are useful but there often isn't sufficient hospital or case management staff to call every patient, Pisarsky says. He suggests developing a trigger list by diagnosis, insurance, or both.

Above all, patients and caregivers need to know who to contact if they have a problem, Bankston says. "Patients see so many nurses and so many different physicians that they may not be sure who to contact if they have a question or a concern. They do nothing, then end up back in the emergency department when their condition gets worse," she says. ■

Five more ways to improve readmissions, according to the experts

1. Look beyond the data. Don't just keep track of which post-acute providers have the most readmissions, advises **Cheri Bankston**, RN, MSN, director of clinical advisory services at Curaspan Health Group. Go a step further and have discussions with the community provider, dig down to individual cases and find out what happened, Bankston says.

She worked with one hospital that experienced a spike in heart failure patient readmissions from one skilled nursing facility. When the hospital team sat down with representatives of the facility and reviewed patient records, they determined that there were several new staff members on the night shift who were not elevating the heads of heart failure patients, which led to fluid buildup and hospitalization.

2. Consult the palliative care team. Referring appropriate patients to palliative care is a critical part of reducing readmissions, says **Teresa Remy-Detty**, DSC, MHA, LNHA, BSN, RN, vice president of post-acute care services for Holzer Health System in Gallipolis, OH.

When the readmission team at the health system analyzed the readmissions, they found that a significant number of patients who were coming back multiple times were having pain issues or were not taking their medications properly and could benefit from a palliative care consultation, she says.

"This was a big piece that wasn't being covered. We have developed a strong palliative care program with referrals being made in the emergency department. Our team is doing a much better job of educating people on palliative care and end-of-life issues," Remy-Detty adds.

> "EVEN ONE NIGHT AT HOME WITHOUT MEDICATION CAN CAUSE PROBLEMS," SHE SAYS.

3. Reach out to embedded case managers. Case managers who are embedded in physician offices and other venues of care can be a great source of information to help you develop a successful discharge plan, suggests **Kathleen Miodonski**, RN, BSN, CMAC, vice president of clinical operations for Post-Acute Network Solutions, a Rosemont, IL-based company that contracts with managed care organizations to provide care coordination for residents in supportive living facilities, also called assisted living centers.

The embedded case managers know what services can safely be provided in which venue of care. For instance, residents of supportive living centers may be able to get home care services and avoid a skilled nursing facility admission, she says.

"These case managers, who often work face-to-face with patients, know the patients, their family members, and support system. They also are knowledgeable about the benefits and services that their health plan covers. This gives them the expertise to help the hospital case manager develop a reasonable discharge plan that is likely to work," Miodonski says.

The embedded case managers want to be actively involved in developing a discharge plan and want to be informed about what

happened in the hospital, she says.

4. Facilitate early discharges. Get patients, especially the elderly, transferred to the next level of care early in the day, Remy-Detty suggests. "Patients, especially the elderly, transition better when they leave earlier in the day," she says.

Elderly patients who are being discharged to home are usually picked up by a spouse who may be 80 or 90 years old and who may have trouble driving at night. In some places, particularly rural areas, many pharmacies are closed at night, making it impossible for patients who are discharged late to get their prescriptions filled, she points out. "Even one night at home without medication can cause problems," she says.

5. Follow up with assisted living residents. Don't assume that patients who are being discharged back to a protective environment like a supportive living facility don't need follow-up, Miodonski says. Patients who are discharged back from supportive living facilities often are at high risk for readmissions, she adds.

Many are in their 80s and even though they are high functioning enough to live alone, they may not remember what happened in the hospital or what medications they are supposed to be taking and why, she says.

"It's essential for case managers to communicate with a clinician at the facility where the patient lives and at the patient's primary care physician office. They need the details of the hospitalization and the treatment plan," she says. ■

Total joint replacement patients need care coordination, too

Many are older, with comorbidities

Case managers shouldn't be complacent about patients receiving total knee and total hip replacement surgery and think that their chances of being readmitted are low, says **Brian Pisarsky**, RN, MHA, ACM, senior managing consultant at Berkeley Research Group and Centers for Medicare & Medicaid Services (CMS) alumni faculty for the Community-based Care Transitions Program (CCTP).

"I see data that shows that readmissions for total hips and knees are pretty high. Some are coming back because they didn't get adequate therapy after discharge or they didn't do well with therapy. Others come back because of comorbidities, surgical-site infections, deep venous thrombosis, or because they didn't follow their treatment plan," he says.

Pisarsky cited statistics that show that 5.5% of total knee and total hip replacement patients come back within 30 days.[1]

The readmission rates may not seem high compared to other diagnoses such as congestive heart failure or pneumonia, Pisarsky points out. "However, hospitals and case managers are surprised when they look at their internal data and find that their perceived very low rate is higher than the published CMS overall rate," he says.

Joint replacement patients frequently are older, sicker individuals who have multiple comorbidities and are readmitted from a skilled nursing facility or assisted living facility during their initial recovery, Pisarsky says. Many times, it's the medical comorbidities, not the joint replacement that brings them back, he adds.

"One problem is that joint replacement patients are often admitted and managed by their orthopedic surgeon without medical consultation. However, they may have medical comorbidities such as diabetes, heart failure, or

EXECUTIVE SUMMARY

Joint replacement surgery may seem routine, but patients are being readmitted to the hospital for a variety of reasons, including comorbidities, poor outcomes from therapy, and deep venous thrombosis. Experts recommend the following:

- Develop triggers for a medical consultation for patients who have chronic conditions and comorbidities or otherwise are at risk.
- Take all of the patient's conditions into consideration when developing a discharge plan.
- Make follow-up phone calls to patients to ensure that they have any prescribed equipment, are participating in physical therapy, have follow-up doctor's appointments, and are taking their medication.

hypertension that need medical management," he says.

According to Pisarsky, the best practice is to place triggers for medical consultation either in the patient's clinical pathway or postoperative order sets. "This hopefully will prevent readmissions because of medical comorbidities," he says.

Look at the entire picture of the patient and not just the surgery, Pisarsky advises. If the patient has chronic conditions, take that into consideration when you anticipate the patient's needs after discharge.

Timely follow-up with a primary care physician as well as their surgeon is important for joint replacement patients, he says. Try to get these appointments made prior to discharge from the hospital, he adds.

Call joint replacement patients a few days after discharge to find out how they are doing and if they are following their treatment plan. Ask if they have started therapy and if they have a follow-up appointment with their surgeon and with their primary care physician, Pisarsky says

If their doctor ordered a passive range of motion machine, find out if it has arrived and if they are using it, he says. Make sure they are taking whatever medication their doctor prescribed for deep vein thrombosis. If their physician ordered compression hose, make sure they have gotten them and are wearing them as directed.

"Sometimes patients don't participate in physical therapy postoperatively and many times complications can arise causing readmissions. It is part of the case manager's role to encourage them to complete their entire treatment regimen and follow their discharge plan," he says.

REFERENCE

1. Procedure Specific Readmission Measures Updates and Specifications Report: Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty. Version 3.0. http://www.qualitynet.org. ■

What home health nurses want from you

Tips from the other side of the hospital door

Transitions from the hospital go smoother and patients are less likely to be readmitted when the providers at the next level of care get detailed and complete information about the patient, says **Sandy Merlino**, RN, MBA, vice president, integrated delivery systems and hospital market development for Visiting Nurse Service of New York.

The Visiting Nurse Service of New York has partnered with New York City hospitals on ways to create smoother transitions and keep patients safe in the community. Here are some ideas from home health nurses on how hospital case managers can make transitions go better:

• Inform clinicians in the next level of care when patients are at-risk for readmissions.

"We risk-stratify patients on our end, too, but we look at it a little differently. It helps to also have information on the patient's medical history and what the case managers see in the hospital," Merlino says.

Make sure the providers at the next level of care have complete medication orders. Problems with medication are one of the big causes of readmission, Merlino says.

• Before patients are discharged, find out if they have the ability to pay for the medication.

If not, work with the physician and pharmacist to put together a plan that will be realistic for the individual. "We get to the patient's home and find out they don't have their medication because they can't pay for it," Merlino says.

• Make sure that patients have a clear understanding of what their medication is for, how to take it, and the importance of taking exactly what the doctor ordered.

"We've encountered patients who found out that the friend or relative had the same prescription but weren't taking it any more. So they were taking medication prescribed for someone else, even though the dosage might be different," she says.

• Share information about the hospitalization with patients' primary care providers.

When the home health nurses at the Visiting Nurse Service of New York check in with patients' primary care providers, they often find out that the doctors are unaware that their patient has been hospitalized, she says.

• Make sure patients have a follow-up appointment with their primary care physicians and inform the home health agency about the time, date, and provider.

"When it's left up to the patient, they either don't make the appointment or if they are told the doctor can't see them for a month, they accept it. The physician office staff need to know that the patient has been hospitalized and needs to be evaluated by a primary care provider," she says.

• Pass along information about family dynamics, she says.

"If it's a big family, it helps us to know who is really in charge, who is the healthcare proxy, and who we can work with to resolve issues," she says.

• Inform the home health agency if there is a psychosocial issue.

"We find that many patients who bounce back have a behavioral health disorder, depression, or anxiety. If we know about it, we can help them get help," she says.

Often, at-risk patients live alone with no support nearby and have no way to get their medication or get to a doctor's appointment, she adds. If the home health nurse understands that there's an issue or barrier up front, he or she can come up with a plan to overcome it.

• Include information in your report about how the patient was functioning before they were admitted and how it compares to their current functionality.

"An elderly couple may have been doing OK before the spouse was hospitalized, but they may not be managing so well after the acute care stay. We work with them to develop their goals and put together a plan to help them achieve the goals. If their goals are not realistic, we come up with a plan to help them see what is more realistic for them," Merlino says.

• Early referrals result in the best transitions, especially if you collaborate with the home health agency liaison on the discharge plan.

Visiting Nurse Service of New York has nurse liaisons who go to the emergency department and the hospital units, attend rounds, and work closely with the case managers to develop a plan of care for patients at risk, she says. ■

Team effort reduces readmission rate by 20% in two years

CM redesign, home visits are among initiatives

After the Holzer Health System in Gallipolis, OH, embarked on a comprehensive readmission reduction program involving the entire health system, all-cause readmissions dropped by 20% in just two years.

"It was a team effort across the continuum. Representatives from every setting helped design the initiative, and we still work together on strategies for preventing readmissions," says **Teresa Remy-Detty**, DSC, MHA, LNHA, BSN, RN, vice president of post-acute care services for Holzer Health System.

The health system's readmission reduction team includes nurses, case managers, pharmacists, and physicians from the health system's acute care hospitals, skilled nursing facilities, home health agencies, hospice providers, and assisted living centers.

The team has come up with initiatives that range from increasing the hours and days that case managers cover the hospital to arranging home health visits, and sometimes physician visits, for patients at high risk for readmission to telephoning the charge nurse at skilled nursing facilities to discuss patients being transferred.

The health system also partnered with the Area Agency on Aging and developed a Community-based Care Transition Program with a grant from the Centers for Medicare & Medicaid Services (CMS). The Area Agency on Aging has placed its care transition coaches in the same department with the case managers and social workers. They work with patients who are identified for the program based on

EXECUTIVE SUMMARY

A team effort at Holzer Health System helped reduce the rate of all-cause readmissions by 20%.

- The case management department was redesigned so care managers and social workers report to the same person, care managers are housed on the unit, and the care management team works weekends, holidays, and evenings.
- The goal is for at-risk patients to have at least one visit from a home health nurse.
- When patients are being transferred to a post-acute facility, the vice president for post-acute care services calls the director of nursing at the receiving facility with information on the patient.

CMS criteria, go on multidisciplinary rounds, and work with the case management team on transition issues. The Agency on Aging's transition coaches who work in the hospital hand off patients to the home transition coaches who work in the community, she says.

One of the early steps in the process was the redesign of the case management system, Remy-Detty says.

At the time, the case management department and the social work department were separate and reported to different people. Now, the departments have been combined and report to the chief medical officer.

Case management staff, either RN care managers or social workers, are in the emergency department to assess and work with patients who come back after discharge. Many of the patients were coming back in because of lack of medication or lack of support at home.

"In the past, these patients would have been admitted or placed in observation. Many times, the case management staff can work with the emergency department staff to get them stabilized and send them home with a home health referral or to a skilled nursing facility," Remy-Detty says.

Before the initiative, the case management team worked only Monday through Friday. Now they work seven days a week including holidays and evenings. They discuss what puts the patient at risk and what needs to be done and goes over readmissions to find the cause, she says.

When patients are identified as high risk for readmission, the case management team talks to the patient and family members about the importance of home health as a care transitions intervention. Some still decline the visit, she says.

The goal is for every patient at risk for readmissions to have at least one home health visit after discharge to home from the hospital or from a skilled nursing facility. One Holzer physician who is active on the readmission reduction team visits patients at high risk in their homes, she says.

The case management team makes follow-up appointments with the primary care provider before patients leave the hospital. The home health nurse is alerted and encourages the patient to keep the appointment, she says.

The home health case managers make frequent phone calls to patients to see how they are feeling and answer any questions or concerns. "We looked into telehealth, but although our high-touch approach takes longer, we've found that talking to patients and getting to know them is more effective," Remy-Detty says.

Recognizing that medication issues often are responsible for readmissions, the team came up with an initiative to deter patients from taking their old medication when it has been replaced with new prescriptions, she says.

When home health nurses make the first visit after discharge from the hospital or a skilled nursing facility to at-risk patients, they gather all of the patients' medications and conduct medication reconciliation. They take all of the old medications and put them in a brown paper bag emblazoned with a big red stop sign and the message "Talk to your doctor before taking any of these medications."

"It works beautifully. The nurse staples the bag shut and the patient knows not to go in the bag. We started with our own home health agency and are working with others to get them to do it as well," she says.

When patients have multiple comorbidities, are frail, or have a complex condition, the hospital arranges for home health visits several times in the first week, sometimes every day, rather than spacing them out over a series of weeks. "The first week, and especially the first weekend, are the most crucial time for patients and the time that they are most at risk for problems," she says.

When at-risk patients are going home with home health, Remy-Detty calls the director of nursing at the home health agency, even if it's not part of the health system. "I let them know that the patient is being referred, tell them what we have been doing in the hospital and what issues have been identified. Many times, the home health agency nurse will call me back with an issue and we will work on it together," she says.

She follows the same procedure when patients are going to a skilled nursing facility or an assisted living center. "It's very time-consuming but it works. I've been doing this myself but am making plans to hand it off," she says.

In some situations, the health system sends a physician to see a patient in the skilled nursing facility. The physician may be a Holzer medical director or may be the attending physician. They check on the patients and work with the skilled nursing facility's physicians to make sure that the patient's needs are being met. When patients are being discharged to a skilled nursing facility, their physician writes orders for three days of medication to go with them.

The hospital hosts lunch-and-learn sessions every quarter and invites administrators, nurses, social workers, and admissions staff from skilled nursing facilities, assisted living centers, home health agencies, and hospice providers. The hospital brings in speakers and has arranged for participants to receive continuing education credits for each session. During lunch, participants at each table brainstorm to solve situations related to care transitions. After the meal, the tables share ideas and solutions they have developed. ■

Hospitals, Council on Aging partner to reduce readmissions

Program cited as CMS Best Practice

When Medicare patients with multiple chronic illnesses are discharged from the hospital, a team of nurses from Carondelet Health Network and care coordinators and navigators from the Pima Council on Aging provide follow-up care coordination in the home and by telephone for 30 days after discharge from the hospital. In some cases, patients may be followed for 45-60 days, according to **Donna Zazworsky**, RN, MS, CCM, FAAN, vice president community health and continuum care for Carondelet Health Network, based in Tucson, AZ.

The Carondelet-Pima Council on Aging Transitional Care Navigation program, a partnership between the two organizations, is participating in the Community-Based Care Transition program developed by the Centers for Medicare & Medicaid Services' (CMS) Innovation Center to test models for improving care transitions from hospitals to other settings and for reducing readmissions for high-risk Medicare beneficiaries.

CMS has called the program a National Best Practice in reducing hospital readmission rates.

The program is underway at Carondelet St. Joseph's Hospital and Carondelet St. Mary's Hospital, both located in Tucson, AZ. It is staffed by nurses from the Carondelet Health Network who conduct medication reconciliation and educate patients on self-management, and care coordinators/social workers, called coaches, from the Pima Council on Aging who help patients access needed social services and coordinate care between providers. They are assisted by Pima Council on Aging navigators. The navigators enter the patients into the database and track where they are in the system, answer the telephone and make outreach calls to patients.

The Care Transitions team members help patients follow their discharge plans and medication regimens, educate them about their diseases and signs and symptoms that indicate their conditions are worsening, provide the social support patients need to maintain their health, and facilitate communication between care providers, Zazworsky says.

"This program is not to be confused with home health. We provide care coordination, not skilled nursing care. Our team works with patients on self-management, education, and medication reconciliation," Zazworsky says. Many patients have social issues that make it difficult for them to follow their treatment plan. These include a lack of transportation, financial instability, low healthcare literacy, lack of social support, and cognitive issues.

"We find that oftentimes patients or family members believe they can manage after discharge but quickly learn that it's more difficult than they thought. Having a nurse and a care coordinator come out to the home helps people learn how to better manage their chronic illness," Zazworsky adds.

Before the program began, a multidisciplinary team from Carondelet Health System researched the literature on readmissions prevention and customized interventions based on Boston University's Project RED (Re-engineered Discharge).

"We met with nursing, the hospitalists, case managers, and pharmacists, and went over each item in the Project RED discharge process and clarified which discipline has the responsibility for each item," Zazworsky says. For instance, the

EXECUTIVE SUMMARY

Carondelet Health Network and the Pima Council on Aging have partnered to provide follow-up care coordination for at-risk patients who are being discharged from the hospital.

- Carondelet nurses visit patients in the hospital to assess them for eligibility and make at least one home visit to conduct medication reconciliation, educate them on self-management, and reinforce discharge education on signs and symptoms that indicate they should call their doctor.
- Care coordinators/social workers from the Pima Council on Aging are called coaches and help patients access social services, visit them in their homes as often as needed, and provide support in following the treatment plan.
- The Transitional Care team developed patient education tools based on color-coded zones for each diagnosis to alert patients on what to do when their condition changes.

bedside nurses educate the patient on their disease, the hospitalist reviews lab values and tests, the pharmacists go over medication changes, and the case managers check to make sure all points are being addressed at discharge.

The team developed patient education tools based on color-coded zones for each diagnosis to alert patients what to do when their condition changes. Signs and symptoms in the Red Zone mean that the patient should seek medical attention immediately. If patients have signs and symptoms in the Yellow Zone, they should call their physician office. The Green Zone indicates that the patient has his or her condition under control. So far, the team has developed the Zone tool for heart failure, acute myocardial infarction, pneumonia, chronic obstructive pulmonary disease, and renal failure and is working on additional diagnoses.

The treatment team in the hospital begins educating patients on how to use the zones. The Care Transitions nurse continues the education during home visits and follow-up phone calls.

Patients who are eligible from a medical aspect are identified for the program by the case managers at the two participating hospitals, using the LACE tool, a standardized risk assessment tool, within the first 24 hours after admission. (LACE stands for Length of Hospital Stay, Acuity on Admission, Comorbidity, and Emergency Department Visits.) Patients also are assessed for social risks. "Some patients may be at low risk medically but have a high risk on social issues," Zazworsky says. The program takes on 150 to 170 new patients each month.

A member of the team, usually a nurse, visits the eligible patients in the hospital, explains the program to them, and gets their agreement to participate. "Often, the patient doesn't enroll the first time they are contacted. Many want their spouse, son, or daughter to hear about the program and asks that the nurse come back later," she says.

A pharmacy technician completes a medication history while patients are in the hospital. "Medications are a huge issue. We start while the patient is in the hospital to find out what they were taking at home and what they will be taking after discharge so we can make sure there are no duplicative or conflicting medications," she says.

Nurses visit the high-risk patients within 48 hours of discharge and make additional visits if necessary. The nurses conduct medication reconciliation and compare the medications in the home with what was prescribed at the hospital. They educate patients about their disease, how to self-manage it, and reinforce how to use the zone tool. They accompany patients to their follow-up physician appointment, answer any questions and reinforce what the physician said. The nurses contact the moderate-risk patients within 48 hours of discharge and visit them in their homes as soon as possible. They make regular phone calls to check on the patients and answer any questions or concerns.

The coaches visit patients with social issues in their home as needed and check on them by telephone to make sure the services they need are in place.

The team is piloting a tele-visit program that connects the patients with team members and a pharmacist via laptop. Family members can receive a link and participate in the face-to-face visit.

Some nurses in the transition program work on the floor at the hospital and spend one day a week making home visits and helping with phone calls.

"This is a wonderful way to have a hospital nurse learn about the continuum of care. When they work on the floor, they start thinking differently," she says.

Carondelet set up a preferred provider network with a home health agency, skilled nursing facility, long-term acute care hospital (LTACH) and an infusion therapy provider. The providers use the Zone tools and other materials developed by Carondelet to ensure that patient education is consistent.

Members of the provider network meet regularly with the Care Transitions team. The providers agree to follow the team's protocols and guidelines, to report readmission rates, and to work with the team on reducing readmissions. "We have asked them to define their transition program so we will know what happens when patients go from the skilled nursing facility to home," she says.

The Aging Transitional Care Navigation Program has its roots in Carondelet's 2009 pilot project to reduce readmissions rates for heart failure.

Patients targeted for the program were beneficiaries of Medicare or Mercy Care, Carondelet's Medicaid plan. They were referred by cardiologists or identified by a risk assessment tool for heart failure.

"In the first year, we recognized that many of the patients had issues around social needs and set up an internship for social work students from the university," Zazworsky says.

"When the Centers for Medicare & Medicaid Services' Innovation Center came out with the Community-Based Transition program, we already had a lot of elements in place," she says. ■

Assessing patients' functional status to identify risks for readmission

Study shows it can make a difference

Patients discharged from an acute care hospital to an acute rehabilitation facility are more likely to be readmitted to the hospital within 30 days if they score poorly on the Functional Independence Measure (FIM) test, which measures a person's ability to perform activities of daily living, according to a study at Johns Hopkins Medicine.[1]

Rehabilitation facilities are required to conduct the FIM within 24 hours of a patient's admission, according to **Erik Hoyer**, MD, assistant professor in the Department of Physician Medicine and Rehabilitation at the Johns Hopkins University School of Medicine, and the department's deputy director of quality.

The FIM has 18 items that measure a patient's ability to walk and to transfer themselves from a wheelchair to a chair, bed, or toilet, self-care issues, such as eating, grooming, bathing, dressing themselves, and the ability to effectively communicate, interact socially, solve problems, and remember important information.

"Functional status is an important factor in a patient's recovery. When a patient cannot move his or her legs or use the bathroom independently, it is telling something about the body's physiological reserve and the overall ability to be resilient to disease. If someone is debilitated, they are at risk for something else happening," he says.

Hoyer does not recommend using the FIM in the acute hospital setting because it takes too long and requires specialized training to use it. But he does recommend that case managers and discharge planners use a tool that measures functionality as part of their assessment of patients.

"Few hospitals assess patients' functional status in a standardized way, but with the new Medicare reimbursement guidelines that cut hospital reimbursement when patients are readmitted within 30 days of discharge, that might drive interest in using functional assessments on patients in general," he says.

At Johns Hopkins Hospital, clinicians use the Activity Measure for Post-Acute Care (AMPAC) developed by Boston University's Rehabilitation Outcomes Center. (For more information on the AMPAC tool, see http://www.bu.edu/bostonroc/instruments/am-pac/.) Nurses administer the tool during the admission assessment and before discharge, he says.

"Using a tool that measures functional ability helps build a picture about the patient's ability to care for himself and assists care coordinators in determining the best discharge setting," he says.

Patients who stay in the hospital for a week may be at a different functional level when they leave than from when they came in, Hoyer points out.

"If care coordinators have a clear picture of a patient's functional ability early on, they can have a conversation with family members, discuss their concerns about the patients' ability to care for themselves, and create a better discharge plan," he says.

Hoyer also recommends helping patients become more mobile and functional during their hospital stay, and that means getting them out of the bed and walking.

"Even patients in the intensive care unit who are on ventilators can benefit from becoming ambulatory. Getting patients out of the bed can improve their outcomes. Every day patients, particularly the elderly, are in bed, they get weaker and more dependent on others. Acute care hospitals have an opportunity to make an impact on that level," he says.

For the study, Johns Hopkins researchers compiled information on 9,405 patients who had been admitted to an inpatient rehab facility directly from an acute care hospital between July 2006 and December 2012. The data included demographic information, primary diagnosis on discharge from the hospital, severity of illness, and FIM scores on admission to rehab. The research showed that patients with low FIM scores were two to three times more likely to be readmitted than those with higher scores, even after considering age, gender, and severity of illness.

REFERENCE

Erik Hoyer, MD, Dale M. Needham, MD, PhD, Levan Atanelov, MD, Brenda Knox, MS, SLP, Michael Friedman, PT, MBA, Daniel J. Brotman, MD: "Association of impaired functional status at hospital discharge and subsequent rehospitalization" *Journal of Hospital Medicine*, Vo. 9, Issue 5, May 2014, pp 277-282. ■

COMING IN FUTURE MONTHS

- Why clinical pathways are making a comeback.
- How to justify more case management staff.
- Working with physicians on end-of-life issues.
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HOSPITAL
CASE MANAGEMENT

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CNE QUESTIONS

1. According to Brian Pisarsky, RN, MHA, ACM, senior managing consultant at Berkeley Research Group, insurance companies have developed their own programs that penalize hospitals for excess readmissions.
A. True
B. False

2. When Holzer Health System began meeting with representatives of the area skilled nursing facilities, home health agencies, and assisted living centers, what did the facilities ask for to smooth transitions?
A. More notice that the patients are coming.
B. A comprehensive medication list.
C. The discharge summary and any patient education.
D. A phone call between the hospital case manager or discharge nurse and the charge nurse at the facility.

3. Kathleen Miodonski, RN, BSN, CMAC, vice president of clinical operations for Post-Acute Network Solutions, suggests that hospital case managers reach out to embedded case managers to get information about their patients. How can the embedded case managers help?
A. They know what services can safely be provided in what venue of care.
B. They know the patients, the family members, and the patient's support system.
C. They are knowledgeable about the benefits the patient's health plan provides.
D. All of the above.

4. Using a risk assessment tool, case managers identify patients who are eligible for the Carondelet-Pima Council on Aging readmission reduction program from a medical standpoint how soon after admission?
A. within 8 hours
B. within 24 hours
C. within 36 hours
D. the day before discharge

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

CM recognition is increasing — but salaries, not so much

More responsibilities but not necessarily more pay

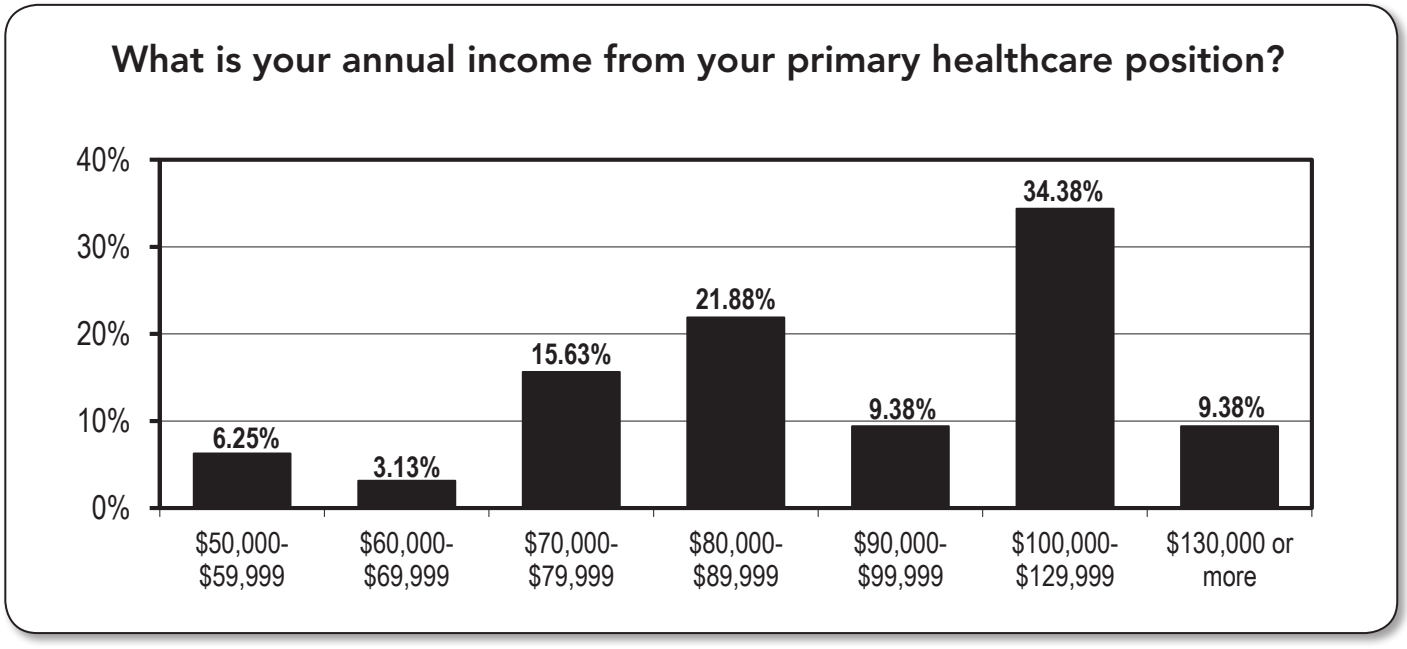
As the Affordable Care Act and other initiatives from the Centers for Medicare & Medicaid Services (CMS) and commercial payers move toward basing hospital reimbursement on quality of care, case managers are getting more recognition for the value they bring to the healthcare system.

"The increased emphasis on quality of care, improving outcomes, and decreasing readmissions puts case managers at the forefront of hospitals' strategies to meet these objectives," says **BK Kizziar**, RN-BC, CCM, owner of BK and Associates, a Southlake, TX, case management consulting firm. The roles of case managers are going to significantly increase since hospital reimbursement will be adversely affected when they don't perform well, she adds.

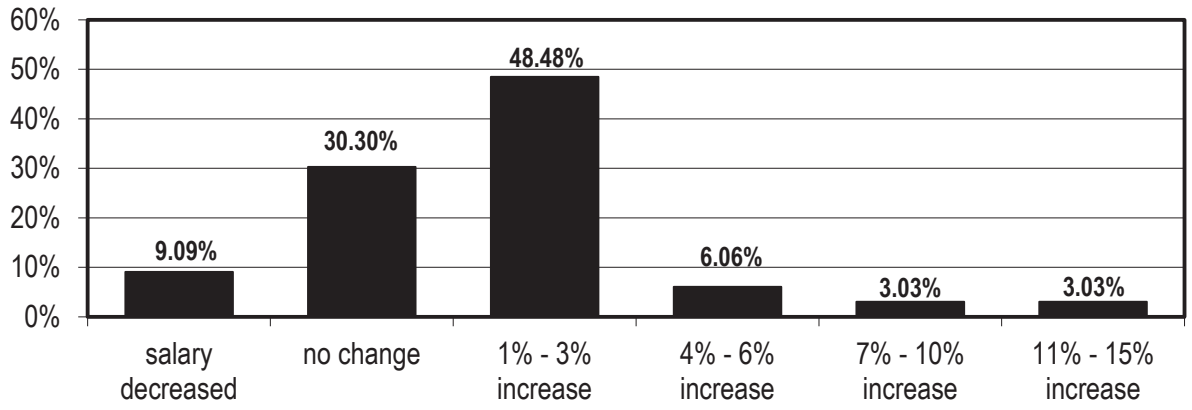
But will case managers be fairly compensated for their increasing responsibilities?

Kizziar is not optimistic. "Hospitals are notoriously short-sighted from a financial perspective. Unfortunately, that often translates to the fact that the value of the people who can make the most effective changes at the ground level are not recognized," she says.

With the increasing responsibilities being handed to case managers, hospitals need to manage staffing



In the last year, how has your salary changed?



ratios rather than increasing compensation, adds **Beverly Cunningham**, RN, MS, vice president of resource management at Medical City Dallas Hospital.

"I'm not sure case managers need additional compensation. We don't compensate a nurse when we add on a new piece of equipment," she says. Instead, she recommends hiring case management extenders to provide clerical support so case managers can concentrate on the tasks that require a license.

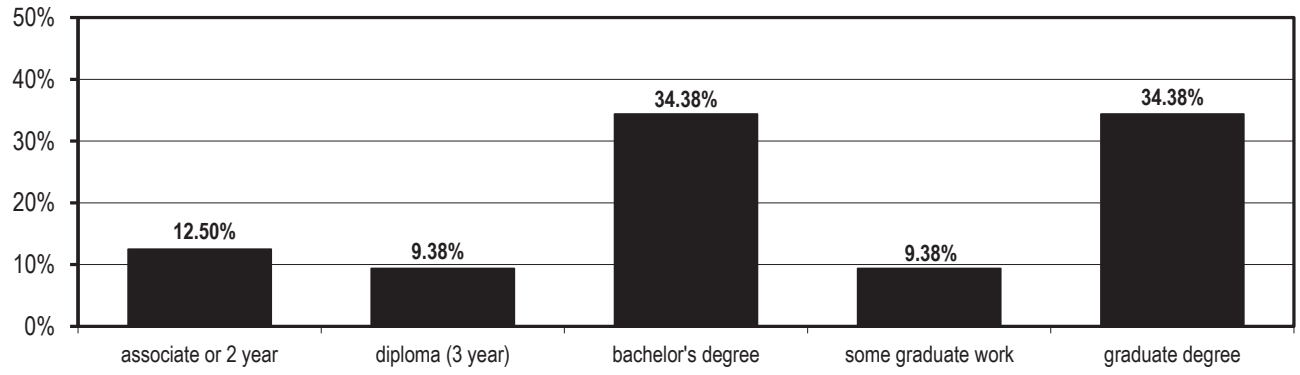
Case managers who responded to the 2014 *Hospital Case Management Salary Survey* reported working long hours, with most receiving only cost-of-living raises. Eighty-five percent of those responding reported putting in more than a 40-hour week and 42% reported working more than 50 hours a week.

The majority of respondents (61%) reported that they got a raise last year but 39% reported that their salaries remained the same or decreased. The majority of raises (49%) were in the 1% to 3% range. Just over 6% of respondents reported raises that exceed 7%.

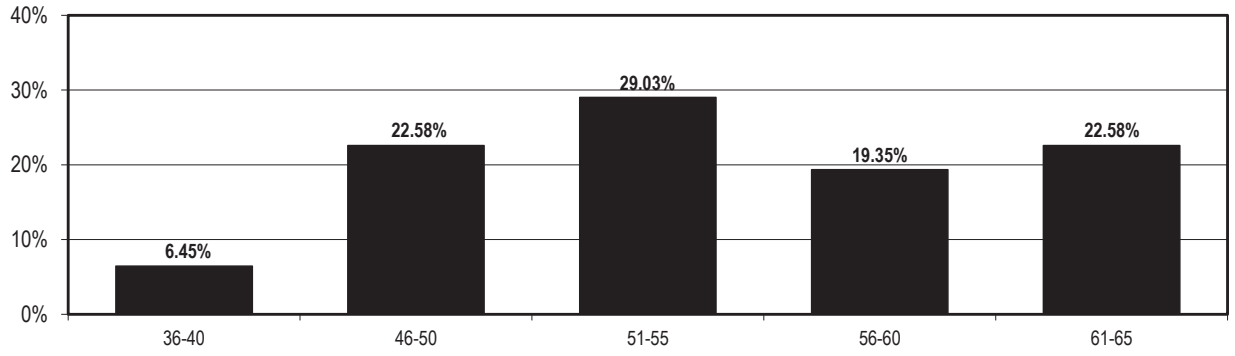
But there is positive news on the horizon, reports **Patrice Sminkey**, RN, chief executive officer for the Commission for Case Manager Certification (CCMC).

"Case managers have an increasing workload and more responsibilities as the Affordable Care Act drives more people into the healthcare system. The good news is that we're seeing an increase in

What is your highest degree?



What is your age?



acknowledgments of the value of case managers around salaries and promotional opportunities," Sminkey says.

Results of the CCMC trend survey conducted in 2013 showed that certified case managers are being rewarded financially and promotions and benefits are increasing, Sminkey says. About 23% of respondents to that survey reported being in decision-making positions, she says. About 35,000 individuals have achieved CCMC certification and work in various practice settings. About 25% of them are hospital case managers.

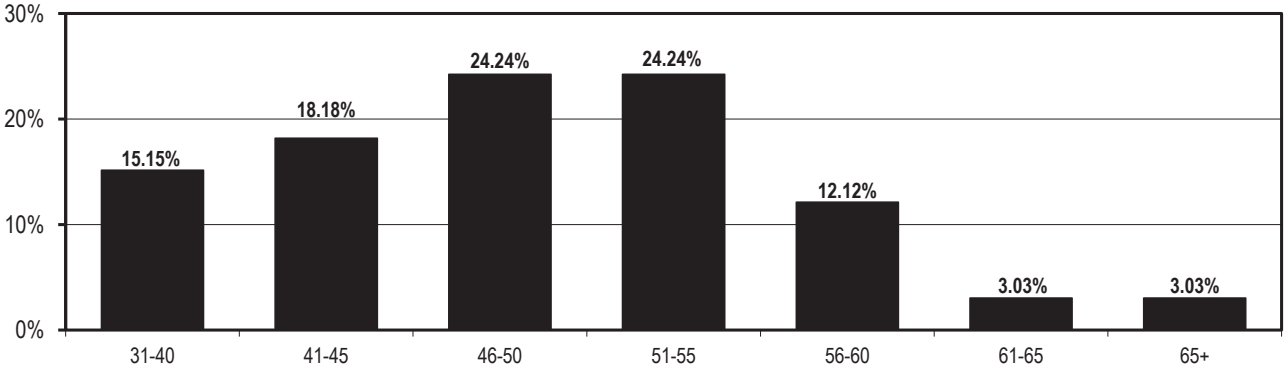
Hospital Case Management readers are older and experienced case managers, with the vast majority of respondents (70%) reporting being over 50. Almost all respondents reported healthcare careers that span 22 years or longer. About two-thirds have been case managers for 13 years or longer.

The average age of case managers certified by the CCMC is 55, Sminkey points out. "There is going to be a continual need for case managers across all practice settings. We need to build awareness among younger nurses and encourage them to move the decision up earlier to increase the workforce," she says.

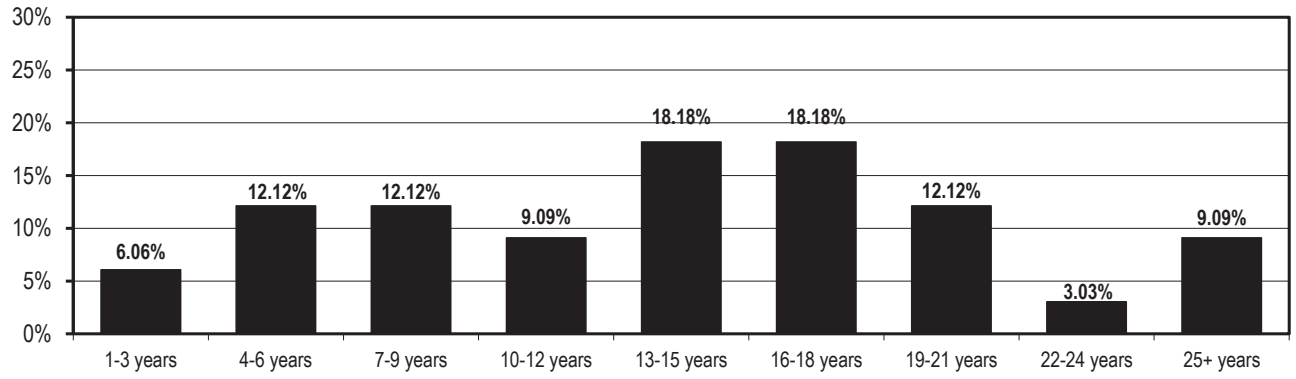
Hospitals continue to require a certain amount of clinical experience before considering an applicant for a case management position, which automatically raises the age level, Kizziar points out.

Cunningham reports seeing a few hospitals that are increasing case management staffing. However, it's getting harder just to fill case management vacancies, Cunningham adds. "We are really having

How many hours a week do you work?



How long have you worked in case management?



to look at support for RN case managers and social work case managers," she says.

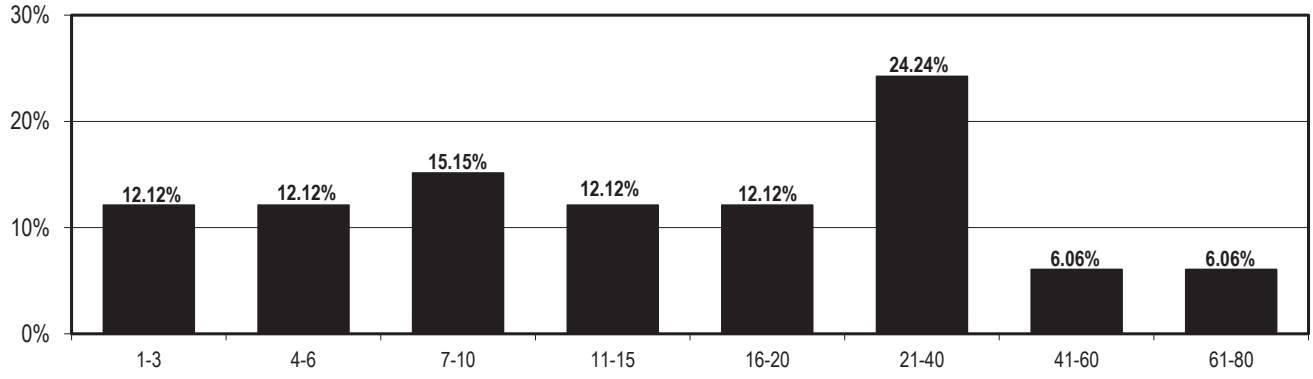
Competition for case managers is very high, adds **Toni Cesta**, RN, PhD, FAAN, partner and consultant in Dallas-based Case Management Concepts.

"Hospitals have to offer competitive salaries in order to recruit the best and brightest," she says.

Cesta believes that case managers should be paid a higher salary than staff nurses. "To be a case manager, you must have skills beyond that of a staff nurse," she adds.

Many new case managers are coming from the bedside, she points out. "Case management salaries have to be competitive with bedside salaries and then some, as most RNs move from 12-hour shifts to eight-hour shifts when they leave the bedside and move into a case management position. What they lose from the convenience of a 12-hour shift, they should make up in salary," she says. ■

How many people do you supervise?



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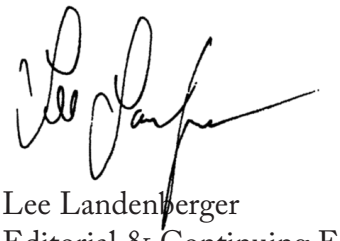

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Editorial & Continuing Education Director