HOSPITAL CASE MANAGEMENT™

the monthly update on hospital-based care planning and critical paths

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IN THIS ISSUE

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As reimbursement shifts, efficient patient throughput becomes critical

From the ED to discharge planning, case managers should be involved

With Medicare's stricter reimbursement guidelines and the likelihood that commercial payers will follow suit, it's more important than ever before for patients to move as quickly and safely as possible through the continuum of care, the experts say.

"Patient throughput has been of utmost importance since the DRG system was created. It's critical now that health care funds are getting so tight," says **Toni Cesta**, RN, PhD, FAAN, vice president, patient flow optimization at the North Shore-Long Island Jewish Health System in Great Neck, NY.

The Joint Commission initiated patient flow standards beginning in 2005 that call for hospitals to "develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital."

Over the past few years, hospitals have made great strides in improving length of stay and already have discovered and corrected the obvious glitches, Cesta says. "For the most part, the low-hanging fruit is gone, but most hospitals still have room to improve efficiency — so the question becomes where and how. Efficiency improvement is a much harder task than just improving length of stay," she says.

Patient flow affects patient safety, quality of care, efficiency, reimbursement, and patient satisfaction, Cesta points out.

For instance, the longer patients stay in the hospital, the more likely they are to develop a hospital-acquired infection. If a patient comes in with a broken hip and has to wait over the weekend before having surgery, it can affect the patient's recovery, putting him or her at increased potential for blood clots, falling, or infections.

Since the Centers for Medicare & Medicaid Services (CMS) has announced its intention not to pay for hospital-acquired conditions, keeping a patient longer than necessary can have a big impact on reimbursement.

A delay in one part of the hospital can affect what happens everywhere else, Cesta says. For instance, if you don't have vacant beds on the medical-surgical unit, patients may have to stay longer in the intensive care unit and surgical patients may have to stay in recovery a long time because no ICU beds are available for them.

To take it a step further, if there are no vacant beds in the recovery room, the patient has to stay in the operating room. Standards of care require the surgeon stay with the patient as long as he or she is in the operating room, Cesta points out. This affects the surgical start time for the next case, consequently making the operating room staff behind for the rest of the day.

Managing bottlenecks

"If you don't have patients in the right area at the right time, it has the domino effect of creating a bottleneck," adds **Connie Commander**, RN, CCM, ABDA, CPUR, president of Commander's Premier Consulting Corp. and immediate past president of the Case Management Society of America (CMSA).

Case managers should help assure that patients are moved as quickly and safely as possible to the appropriate levels of care, she says.

"Patients who sit in the emergency department for four hours or longer create inappropriate utilization of resources," Commander says. "What throughput is all about is evaluating patients, assessing their needs, determining what level of care they need, and moving them to that level, whether it's a higher or lower level of care." For instance, patients who are not in critical condition should not remain in the intensive care unit, even if their physician prefers the staff ratio in the ICU, she says.

"When noncritical patients are in an ICU bed, it can create a backlog but it's also a huge quality-of-care issue. The ICU staff know the patient is not meeting criteria for remaining in the intensive care unit. This takes away from the priorities of other critically ill patients who do require their attention," she says. The other impact is to the patient who should be moved to another level of care but who remains in the ICU, away from family and friends, perceiving that they are still at the critical level of care, she says.

Use skill set of clinical staff

The skill set of the clinical staff and the resources of the unit are not being utilized appropriately when patients aren't moved appropriately and in a timely manner through the continuum of care, she adds. When you talk with physicians about moving a patient to another level of care, it is helpful to tie it back into quality-of-care issues, including the fact that the bed could be used for another patient waiting for that ICU bed, Commander suggests.

"Physicians tend to be focused on the patient that is in front of them. We need to raise the awareness that while it may not hurt one patient

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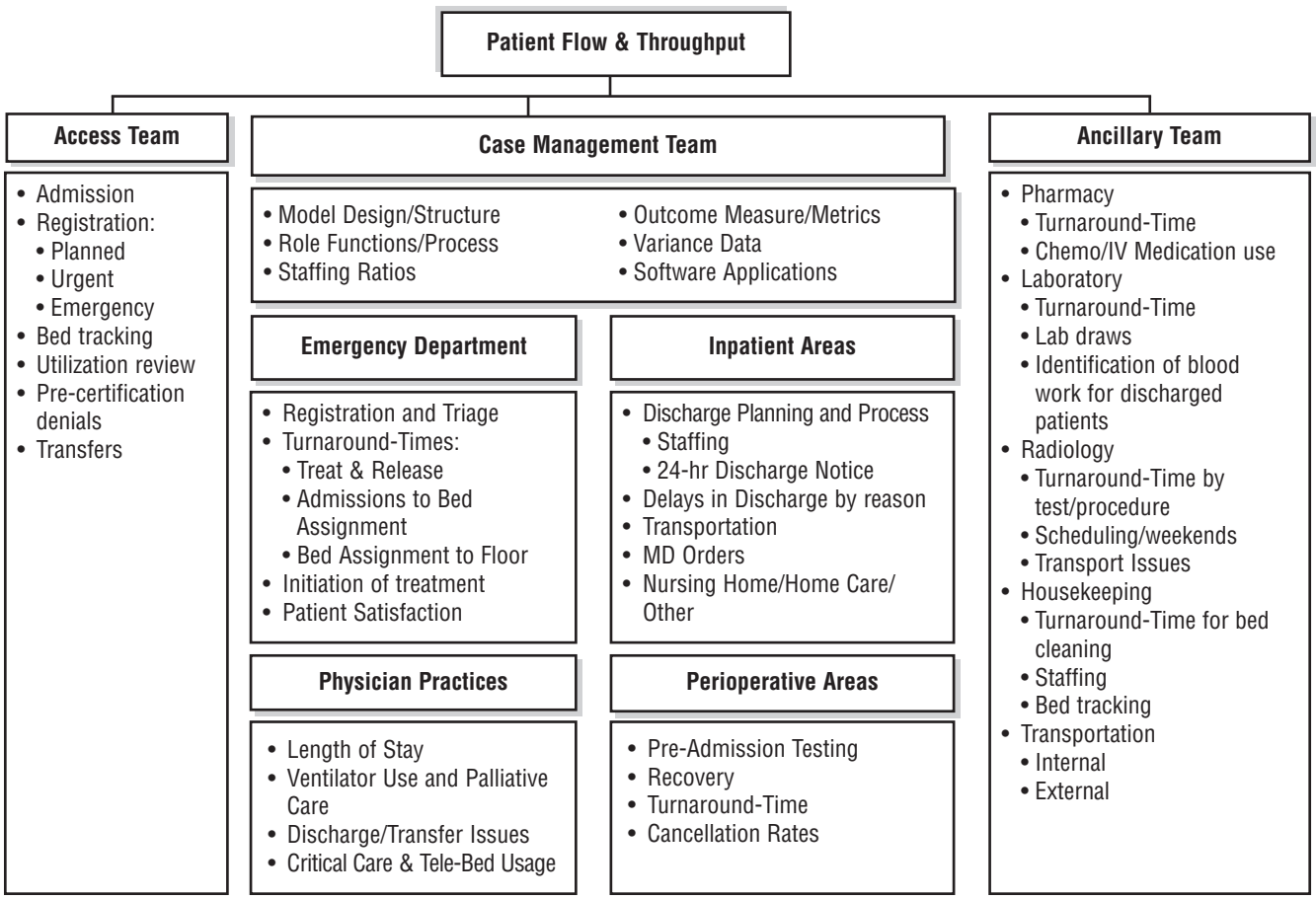
Patient Flow and Throughput Organizational Overview



Source: Toni Cesta, RN, PhD, FAAN, North Shore-Long Island Jewish Health System, Great Neck, NY.

to stay at a higher level of care than necessary, it is hurting the person who is holding somewhere else," she says.

Barriers to patient throughput can occur in all areas of the hospital but often begin in the emergency department, says **Charlotte Thompson**, RRT, BS, MBA, manager in KPMG LLP's health care advisory practice.

Good admission, discharge criteria

Case managers can play an integral role in patient flow, not just by discharging patients but by being involved in the intake process, she adds. "If hospitals don't utilize the right admission and discharge criteria, the patient may not be admitted to the right unit. Then they have to be moved and that becomes a patient safety issue and a patient satisfaction issue. It's been my experience that when there is a case manager in the emergency department, patients are admitted to the right unit the first time," she says.

When Thompson consults with hospitals about throughput initiatives, one of the first things she asks is: "Is there a case manager in the emergency department?"

Thompson recommends that hospitals assign a case manager to the emergency department and track the effect on patient flow over a period of time, including how many times patients are admitted to the right unit and how many patients meet admission criteria.

When there are delays in the emergency department, it's often because there are barriers to discharging inpatients in a timely manner, Thompson says. She advises hospitals look at where the barriers are occurring and what is clogging patient flow.

"In many instances, the problem is that inpatient

beds are not freed up as quickly as they could be due to a lack of pre-planning," she says.

Discharge needs list

She suggests that case managers develop a patient discharge needs list, beginning when the patient is admitted.

"Instead of scrambling to set up everything the patient is going to need when the doctor writes the orders, the case managers should have discharge needs completed and in place in advance. Ordering equipment for the home, setting up a ride home, and a lot of other tasks can be completed in advance," she says.

Thompson was able to help the case management staff in one hospital decrease overall length of stay by half a day by pre-planning and making sure that everything was in place for patients to go home as soon as doctors wrote the discharge order.

Lack of communication often creates a barrier to discharge, Thompson points out. "Many times the patients and family members don't know when the patient will be discharged. I suggest placing a small white board in a patient's room near the door. The board should include the discharge date and the patient's responsibilities, such as setting up a ride home. This tiny white board can have a big impact," she says.

Communication key to flow

Good communication among members of the multidisciplinary treatment team can go a long way toward improving throughput, Thompson says. Set up visual cues about pending discharges where the entire treatment team can see them, whether it's on a chart or in the electronic patient/bed tracking system.

"In today's busy health care environment, clinicians tend to operate in silos. When the team doesn't communicate effectively, it will affect the movement of the patient, whether it's intake, throughput, or discharge," she says. Thompson suggests group rounds that involve the entire treatment team, including case managers, and daily communication between the nurses, physicians, and case managers about the discharge process.

Discharging patients in a timely manner is important but it's merely the end of the throughput process, Cesta points out.

"Case managers must deal with utilization, patient flow, and coordination of care. Discharge planning is just another piece and it's not the only piece," Cesta says.

Don't fall into the trap of trying to discharge all patients by a certain time of day, she warns.

"Patients should leave the hospital when they are clinically ready to leave and everybody isn't clinically ready to go at 10 a.m., or 11 a.m., or noon. Some patients may be ready for discharge at 6 p.m.," she points out.

Discharging a lot of patients at the same time creates backlogs and taxes the resources of the hospital, Cesta says. Transportation, housekeeping, and other parts of the hospital will be overwhelmed if everyone is discharged at once, she adds.

Falling into that mindset has the potential to lengthen patient stays, she continues. For instance, if a patient isn't clinically ready to go home until late in the day and goes home at 6 p.m., does it count as a late discharge or is it an early discharge because the patient didn't stay overnight?

"If hospitals discharge patients throughout the day as they become clinically ready to go home, the beds can be ready to accommodate patients as they start to come into the emergency room," Cesta says. ■

CMs' role in patient throughput initiatives

CMs know where the roadblocks are

Case managers play a critical role in patient throughput and their voices should be heard whenever hospital staff meet to discuss barriers to admission and discharge and how they can be eliminated, says **Charlotte Thompson**, RRT, BA, MBA, manager in KPMG LLP's health care advisory practice.

"Case managers are sometimes excluded from throughput teams but they should be a part of this multidisciplinary decision-making group. They are in a unique position to see where the roadblocks occur and to do something to expedite patient flow," she adds.

As part of their job, case managers identify delays and deal with them as they occur. This puts them in a good position to play a supportive role in identifying patterns in delays, adds **Toni Cesta**, RN, PhD, FAAN, vice president, patient flow optimization at the North Shore-Long Island Jewish Health System.

Hospitals have to understand where the problems are before they can decide what steps to take to make maximum impact, she adds. "It's not always so obvious where delays occur. You might know anecdotally what is happening but you need data to support it before developing an improvement plan," Cesta says.

Hospitals should have several teams that look at patient flow and throughput, collecting data and identifying where the biggest opportunities are. Staff who are working closest to patient care should serve on those teams, she says.

The teams should brainstorm on possible holdups to patient throughput, collect data on potential glitches, analyze the data, and identify the greatest opportunities for improvement, Cesta says.

Take the team approach

Thompson advocates the team approach to patient care and patient throughput.

"When multidisciplinary teams meet and discuss patient flow, you can almost see the light bulbs go off. These meetings break down the cultural silos that occur in today's busy hospitals. The disciplines begin to actually communicate with each other and start resolving issues," Cesta says.

A multidisciplinary throughput team should include the unit secretary, housekeeping, pharmacy, lab, radiology, and transportation as well as representatives from the clinical team, she says.

Case managers should deal with problems as they occur and point out patterns at the patient flow meetings, Cesta says. For instance, if a hospital doesn't perform MRIs on Sunday and the case managers observe patients who stay longer because they have to wait until Monday for the MRI, they should point it out to the throughput team.

"Improving throughput involves providing care when it's needed and that means seven days a week, as opposed to five days a week. If hospitals provide certain services only Monday through Friday and patients are languishing in the hospital over the weekend, they're not getting what they need from a quality-of-care standpoint," Cesta says.

Spreading services out across seven days a week optimizes a facility's resources and personnel and helps get patients through the continuum of care in a timely manner, improving quality and patient satisfaction along the way, she adds.

"Patient flow is more than just discharging patients. It's the entire process from the time that patients come into the hospital until [they leave]," Cesta says.

Identify opportunities where patient flow may be affected, she suggests.

Look at all the places in your hospital where case managers can affect patient throughput. Identify what you want to measure in each category and set targets.

Determine where you are off-target and focus on specific issues and initiatives that can help clear up the problem.

Look at how patients access the hospital. How long are they waiting in the emergency department? Are patients being admitted inappropriately, taking up beds that other patients need?

All of that affects patient flow, Cesta says.

Look at laboratory and ancillary services and track the delays in getting the results.

Examine the relationship between case management and housekeeping. Track how quickly housekeeping is notified when a bed is ready and how long it takes for them to clean the room.

Internal transportation may be another potential glitch. Look at how patients are transferred to ancillary departments for tests and procedures and how long it takes. Find out how long it takes for a patient to be transported out of the hospital when they are discharged.

"There are a thousand little things that may mean only short delays, but they can all add up," Cesta says.

Evaluate preadmission testing time and how long patients wait for the operating room. Track operating room cancellations, how often they occur and why. ■

Dry-erase board improves communication, discharge

Nurses, CMs write notes to each other

A simple communication tool used by case management and nursing has decreased the turnaround between when discharge orders are issued and the time the patient is out the door at North Broward Medical Center in Deerfield Beach, FL.

When case managers and nurses brainstormed about how to facilitate discharges, the group came up with the idea of using a dry-erase board that hangs in the case management office on each floor and has a space for the nurses and case managers to communicate about pending discharges, patient

needs, and barriers to discharge, says **Gavin V. Malcolm**, LCSW, coordinator of social services at the hospital.

Simple tool makes big changes

The improved communication has decreased the time it takes to discharge patients to home by four hours and the turnaround time for patients being discharged to skilled nursing facilities by hour and a half.

"It's a simple tool. It doesn't add more paperwork or documentation but it facilitates communicating back and forth. It's made a huge difference in the turnaround time. When you're talking about Medicare length of stay, every hour counts," says Malcolm.

The board is divided into categories to facilitate communication. For instance, one column is for skilled nursing facilities discharges; another is for patients who will need home care and/or other services.

To protect patient confidentially and comply with the Health Insurance Portability and Accountability Act regulations, the case managers write the patient's room number, not the name on the communications board.

The case managers make the morning rounds with the charge nurse to talk about potential discharges. They make notes on the boards and update them as orders come in throughout the day.

Since each floor has different processes and different personnel, staff on each floor use the dry-erase board a little differently, Malcolm points out.

If the nurse tells the case manager during morning rounds that a patient is likely to be discharged to a skilled nursing facility the following day, the case manager enters the information on the board along with a to-do list, such as setting up an ambulance to transfer the patient or making sure the patient gets a physical therapy evaluation.

When the doctor comes in the next morning and writes the discharge orders, whoever is in the case management office knows what needs to be done and what has been done to get the patient ready.

"Even if the case manager who is in charge of this case isn't there, the rest of the staff know what needs to be done," Malcolm says.

If the nurse has a question or a concern and the case manager isn't in the office, she can just write the question on the board, Malcolm says. The nurses write the discharge orders on the board or call them into the case management department, rather than having to track down the case manager.

The nurses and case managers meet regularly for team building, an activity that has helped each discipline understand what the other does, as well as facilitating the best possible patient care.

"We have focused on reducing Medicare length of stay and how we can do it creatively while assuring that the patients are getting appropriate care," Malcolm says.

In the past, the nurses and case managers would leave notes for each other or leave voice mail messages.

"Sometimes things fell through the cracks. The notes got lost or people were too busy to check their voice mail. We were brainstorming on ways to eliminate this happening," he says.

Electronic discharge planning manual

Developing an electronic discharge planning manual that contains community resources and other venues of care also has been a tremendous help in facilitating discharges, Malcolm says.

"When we had our resources in a book, we had to change it every few weeks, print out more pages, and renumber them. Now it's on-line and we can make additions and deletions quickly and anyone in the hospital can access it if there is not a case manager in the hospital and a discharge is pending," he says.

North Broward Medical Center is a 409-bed hospital with a Level 2 trauma center, and is part of North Broward Health District, a four-hospital health care system.

At the medical center, case managers are unit-based. The hospital typically assigns two nurse case managers and one social worker to each floor.

Case managers work on weekdays from 8:30 a.m. to 5 p.m. and from 8:30 a.m. to 6 p.m. on Saturday. One nurse case manager or social worker stays until 8:30 p.m. to handle late discharges. The staff rotate being on call on Sundays.

The case managers are responsible for utilization review and discharge planning. The social workers focus on discharge planning for the more difficult cases as well as supporting the family throughout the hospital stay and helping them access community resources if needed.

The hospital's case management software is linked to the electronic medical record and is updated throughout the day.

The case managers enter a standard discharge plan for each patient into the case management software. The plan goes through all of the steps

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CRITICAL PATH NETWORK™

Persistence pays off when placing difficult patients

Case study shows the benefits of networking

It took more than 260 days, hundreds of hours on the telephone, and a lot of networking and brainstorming for Chesapeake General Hospital in Chesapeake, VA, to find post-acute care for a seriously ill pediatric patient.

But persistence and patience paid off and the care management staff were able to place the patient in a pediatric rehabilitation center where he got the therapy he needed to be discharged to home.

The patient, a 17-year-old boy who suffered a blood clot in the brain that left him severely impaired, was a challenge for the 310-bed acute care hospital.

"This case was a real heartbreaking one and an example of how difficult some placements can be. This boy had multiple needs and required almost around-the-clock complex care. Because he was younger than 18, he qualified as a pediatric patient but he was the size of an adult. Everything about him was adult, except his age," says **Roxana Ballinger**, RN, CCM, director of care management.

The hospital's placement specialists, who are social workers, facilitate 130-150 post-acute placements in a typical month.

However, the patient — let's call him John Smith — needed placement in a pediatric hospital that could provide intense rehabilitation services. Placing ventilation patients with multiple needs is difficult in any circumstance but even more so when the patient is a juvenile. It was particularly problematic for placement specialists whose expertise is placing adult patients, Ballinger says.

Finding a post-acute placement for Smith was a team effort that involved networking with social workers and case managers at hospitals across the country, doing research on the Internet, and brainstorming in the hospital's multidisciplinary long-stay meetings, she says.

"Networking proved to be very important when we were working to place this patient. It was a big help that our staff know case managers and social workers at other facilities. You may think you'll never need these kinds of contacts;but when a case like this comes up, you need everybody's help," she adds.

The patient was gravely ill when he came in to the emergency department. He had a blood clot in his brain that resulted in peripheral neuropathy, which left him mentally aware but with an unresponsive body. The cause of the blood clot, about the size of a fist, was never determined.

The day after surgery to relieve the pressure on his brain, both of his lungs collapsed; he was on a ventilator and received IV antibiotics and IV steroids.

Eventually, he received a tracheostomy and a feeding tube but still required total care — he couldn't sit up on his own, couldn't walk, feed or dress himself. His needs were so extensive that discharging him to home, even with 24-hours-a-day care, wasn't an option.

He spent about three months in the ICU before he was transferred to the medical floor. Even then, his room had to be located close to the nurse's station, and the nurses who cared for him carried a smaller caseload because he needed so much monitoring and his care was so complex.

Smith became acutely ill and returned to the ICU twice during the 280-plus days he was at Chesapeake General.

The hospital has 11 full-time RN case managers

and two PRN case managers who go wherever they are needed. Ten of the full-time case managers work on the inpatient side and are unit-based. There is a full-time case manager in the emergency department.

The case managers handle all the utilization review, Medicare review, managed care reviews, and discharge planning for patients being discharged to home who need transportation and home health.

The department includes four placement specialists who are social workers and are responsible for placements in post-acute care. Two payer specialists work with insurance companies and handle denials and appeals.

When the young man had been a patient for about three weeks, **Jessica York**, SW, placement specialist, began looking for post-acute placement options, taking into consideration his mother's wishes for her son to stay in Chesapeake.

"By then, his permanent skilled needs were apparent. We knew that he was going to need a lot of rehabilitation to become functional and that wasn't going to happen in an acute-care hospital," Ballinger said.

Lake Taylor Transitional Care Hospital, the only hospital in the area that took pediatric patients, had a long waiting list and the mother preferred for him to be near home.

"His mother wanted to take him home but knew she couldn't. She knew the best place would be in a rehabilitation facility so he could begin making progress," Ballinger says.

York began contacting children's hospitals in the area to find options for placing difficult-to-place pediatric patients.

"They gave us the names of a few facilities with long waiting lists. There simply are not enough facilities to take care of young people who are critically injured and likely to have care needs for the rest of their lives," she says.

York began contacting hospitals further and further from Chesapeake, eventually, scouring the entire East Coast, looking for a bed for Smith. Meanwhile, he remained at Chesapeake General Hospital where the total cost of care was growing increasingly expensive and difficult for the hospital to recoup.

Smith's insurance company paid for some of his acute care but denied any rehabilitation benefits, which made it even more challenging to find a place for him.

"Medicaid was going to be his payer for rehab and Medicaid in the state of Virginia doesn't pay much. The patient was on a ventilator, a tracheostomy, and had a feeding tube. He needed intense physical therapy, occupational therapy, and speech therapy. His needs were complex and that made it even more difficult to find a place for him," Ballinger says.

Many times, the rest of the staff pitched in and took care of York's caseload so she could work full time on finding a place for the young man.

"It was highly unusual for a staff member to devote entire days working on one person's case but it was the only way to make any headway with him. If she hadn't spent so many hours on the case, he would have been here much longer," Ballinger says.

The entire care management team supported York throughout the process.

"She became very emotionally involved in the case and went out of her way to do whatever she could for the patient and family," Ballinger says.

The social work team spent a lot of time with the mother, helping work through the emotional trauma of having a critically ill child. They helped her apply for Medicare and arranged transportation so she could visit her son in the hospital.

York made frequent follow-up calls to the post-acute facilities, which had the facilities to care for a patient such as Smith.

"These facilities wanted enormous amounts of information about him and wanted constant updates. We had to fax some information. Other facilities wanted it electronically. We were constantly pushing to find a place," Ballinger says.

Finally, as York networked with other facilities, someone referred her to Kluge Children's Rehabilitation Center, affiliated with the Children's Hospital at the University of Virginia. After studying his condition for a few weeks, they agreed to take Smith.

"They looked on him as a young boy with a life ahead of him. Since he was on Medicaid, taking him was not a good business decision but they looked on him as a challenge, as someone they could help," Ballinger says.

Smith's mother, who had insisted that her son stay at Chesapeake General even when he was stable enough to be transferred to a pediatric facility, was anxious about transferring him to Kluge.

"She was very nervous about him leaving the hospital. He had been here so long, he felt like this was his home and so did his mom. She knew the nurses and the therapists and was comfortable with everybody," Ballinger says.

The care management team assured her he would get good care and put her in touch with the Kluge staff. They explored temporary housing options in Charlottesville and offered the mother a bus ticket so she could be with her son as he adjusted to a new facility.

York kept in touch with Kluge and learned that the young man was released to home with 24-hour care.

Ballinger offers these tips for placing difficult patients:

- Be patient and keep trying. Often it takes contacting the same facilities over and over to remind them you have a patient who needs their services.
- Designate someone to work on the case almost exclusively.

"These cases are so complicated that no one can carry a full load of nursing home and rehab placements and handle a complex case," she says.

- Network constantly with everyone you know. By talking to one person who referred her to another and another, York found Kluge Children's Rehab. ■

CMs take lead in discharge improvement initiatives

Project increases percentage of discharges by noon

At Ingham Regional Medical Center in Lansing, MI, case managers take the lead in a multidisciplinary effort to increase the number of patients who are discharged by noon.

"We make it clear that even though we are working as a multidisciplinary team, the case manager is ultimately responsible for running the show," says **Dennis Perry**, MD, MPH, director of case management and utilization review.

When the project was begun, the hospital's overall percentage of patients discharged by noon was 13.5%. In three months, the figure had climbed to 19%. It now has trickled back down to 17%, Perry says.

"The concept is out there and that's a good thing. We're working to overcome the barriers to an early discharge so we can increase the percentages," he adds.

Often, in the day-to-day work that takes place in the hospital, the treatment team loses sight of potential discharges, Perry says. Mornings are typically a busy time for the nursing staff and getting patients ready for discharge are not high priorities, he points out.

Case managers play a vital role in keeping the team focused on and working toward the goal of a speedy discharge for all patients, he adds. "Many times, a team gets interested in changing the way they do things but after a short period of time fall back into their old pattern. I want to make sure that doesn't happen in this case," he says.

At Ingham, case managers are assigned by floors and work with social workers who are assigned to multiple floors and handle discharge planning, utilization review, and communication with insurers. The hospital has patient care managers who act as nurse managers on each floor. They are not part of the case management department.

Patient care managers

"Getting the patient care managers on board has made a difference in improving discharges because the nurses report to them," Perry says.

Every day, case managers review the charts of all patients on their floor to get a sense of who might be a potential discharge for the next day. If they determine that it appears that a patient's goals have been met, they work with the admitting physician to ensure that everything will be in place so the patient can be discharged the next day.

They review the patients with the patient care manager and communicate with the staff nurse.

"We want to make sure that everyone is on the same page about which patients should be going home the next day. We give a heads-up to the attending physicians so we can get the orders in place and get all of the patient discharge needs taken care of ahead of time," Perry says.

The team works together to make sure the patients and family members are aware that discharges should take place by noon, and not 6 p.m. when the family member gets off at work, Perry says.

"We educate the patients from the get-go about why they are in the hospital and when they can expect to be discharged. We make sure that they understand that the case managers are working from Day 1 to take care of their discharge needs and to make going home as smooth as possible," he says.

The case management department recently has begun a morning report meeting with the case

managers, the social workers, the home care coordinator, and other key players. During the 10-minute meeting, the case managers bring up the patients they anticipate will be ready for discharge the next day.

"The key players discuss the patients, how ready they are for discharge, and what they will need to be ready for discharge the next day. The meeting the next morning serves to remind the team of what has to happen to get the patient discharged," he says.

When the hospital began its discharge initiatives, two units piloted the effort.

"I was able to work closely with the case managers and patient care managers on those units and to have regular discussions to ensure that everything was working as it should and that the team was continuing to focus on a speedy discharge," Perry said.

When the team brainstormed to identify obstacles to a speedy discharge, they came up with three potential barriers — patient expectations, ancillary services, and physician cooperation.

"The case managers took care of the patient expectations pretty quickly. They give them notice of when they can expect to be discharged and tell them if they don't have a ride home, the hospital will get them a taxi. The case managers know how to say the right thing to prepare the patients for discharge," Perry says.

Initially, Perry sat down with the case managers and the patient care managers every week to discuss the discharge initiative. "That was difficult from a timing standpoint," Perry says.

Now the team discusses discharges and what holds them up in the regular case management meetings, he adds.

The hospital rolled out the system on two more units six weeks later, gradually involving every unit in the hospital. The first two units were 6 South, a medical floor with a large percentage of renal patients, and 5 North, a medical-surgical floor.

Early results positive

Before the project began, only an average of 12% of patients on 6 South and 13% of patients on 5 North were going home before noon. After the project began, the figures rose to 20% for 6 South and 18% for 5 North.

"It was very promising. We maintained the noon discharge percentages for three months," he says.

The next two floors that began the discharge initiative had a high volume of cardiac patients and heart catheterization patients. "These units already had a fairly high discharge rate but we were able to raise it from 20% to 25% within two months," he says.

Hitting a plateau

Then the team hit a barrier and the discharge rates stopped improving.

"The problem was, we were asking physicians to be everywhere at one time. We were working to get the discharges completed earlier in the day and they were overwhelmed and not able to effectively change what they were doing," Perry says.

At Ingham, a hospitalist group admits and cares for a large percentage of the medical patients. The hospitalists were short-staffed on physicians who make the rounds, and in many cases, the attending physicians had not been on the unit to discharge the patient in a timely manner.

The case management department has been looking at ways to overcome the barrier to a speedy discharge.

"We are anticipating a change in the way the hospitalist service works. There will be a significant increase in the number of physicians rounding on a daily basis," he says.

Under the new system, the case managers will guide the hospitalists as to who they should be seeing first and then ensure that the discharge summaries are complete.

The hospitalist group will dedicate several physicians to handling discharges.

"Our goal is to have 30% of the patients discharged before noon. Statistically, success in discharging patients early in the day is often dependent on the floor. There may be only eight patients waiting for discharge, but if they get four people out by noon, the discharge rate is 50%," Perry says.

Perry sees the discharge initiative as an ever-evolving process that is likely to have its ups and downs.

"We have learned that it is important to set a goal and come up with a plan to meet the goal, but that's not enough. You should always be looking at barriers and keep working toward the goal. It takes a lot of energy to keep a system going in any large organization, particularly when people are accustomed to doing things a certain way," he says. ■

(Continued from page 134)

necessary for discharge and includes names and telephone numbers for family members or friends, medication issues, and other information. The plan includes the patient and family members' first, second, and third choices of post-discharge facilities, such as skilled nursing facilities, along with telephone numbers and names of people to contact.

"All of the case managers have access to the latest discharge plan and can easily see what steps need to be taken and determine any barriers to discharge. They can access the discharge plan remotely from anywhere in the hospital if it's after hours and they're on another floor," Malcolm says.

In addition, if a patient is being discharged when there is no case manager in the hospital, the staff can pull up the electronic medical record and know the steps they need to take for discharge, any issues or barriers, and contact numbers for the patient's family, he adds.

"We focus on discharges in the morning if possible, so if necessary, we can get patients transferred to another facility in time for them to settle in. If they're going home, we try to get them out of here so they can be there before dark," he says.

People who don't have a ride home and are able-bodied can take advantage of a free van service. The hospital also has a contract with a local taxi company to assist with transportation for patients.

"The case management staff on each floor send a representative to show that we are committed to the floor and this helps build relationships and a sense of working as a team," Malcolm says.

The case management representatives at the meeting provide feedback to the rest of the staff about customer service issues. For instance, if the patient complained that he was discharged too quickly or that the pending discharge wasn't communicated well, the representative takes it back to the team to discuss what could have been done better. ■

GUEST COLUMN

Reduce your hospital's preventable readmissions

Target premature discharge, outpatient management

By **Patrice Spath**, RHIT
Brown-Spath & Associates
Forest Grove, OR

Reducing readmissions has become an increasingly important goal for hospitals. Medicare is evaluating various payment incentives to encourage lower rates of preventable readmissions. This may include withholding payments and offering incentive payments, as well as public reporting of hospital-specific readmission rates. Although today, hospitals have little incentive to invest in managing post-hospital care, many already are positioning themselves for this new imperative by implementing outpatient case management programs for elderly patients, those with chronic diseases, and other "revolving door" patients. These programs include home visits by nurse practitioners and other caregivers and regular phone calls to answer questions and encourage patient compliance with follow-up instructions.

These post-hospital patient management strategies do not replace an effective inpatient case management program. In addition to traditional care coordination activities, hospital case managers can be instrumental in identifying preventable hospitalizations. It is important to work closely with primary care physicians, home health agencies, and other out-of-hospital providers to identify inpatient admissions that might represent inadequacies in outpatient management practices or premature discharges. Evaluation of these cases can help pinpoint where changes are needed to reduce readmission rates.

Taking the first step

The first step is to identify the magnitude of potentially preventable readmissions. Use your clinical/financial information system to find patients admitted to the hospital with "ambulatory care sensitive conditions" (ACSCs). These are conditions for which the probability of hospitalization could be reduced by adequate primary care. ACSCs have been endorsed by the Agency for Healthcare Research and Quality as a measure of access to health care and can also be used to screen readmissions for potential problems. To select these conditions, researchers conducted a literature review and obtained clinical guidance

from practicing physicians.

In **Figure 1** is a list of ACSCs for pediatric and adult patients. All admissions could be evaluated or just those that fall into the category of a readmission (within a specified time period — usually up to 30 days).

The circumstances surrounding each hospitalization for an ACSC condition should be analyzed to determine what, if anything, could have been done to prevent the admission. Ideally, this analysis is undertaken by a multidisciplinary group, such as the utilization management committee or a group with similar case review responsibilities. To determine whether the hospitalization could have been prevented and how it could have been prevented will often require review of outpatient records (clinic, home health, etc.) as well as the inpatient chart.

Some patient hospitalizations are due to the natural course of their chronic disease. Some of the hospitalizations might be related to premature discharge during the last hospital stay or ineffective or inadequate outpatient services — for example, the patient may not have had adequate access to primary care services, which resulted in an exacerbation of their condition. A patient's access to adequate ambulatory health care services can be influenced by many factors, including:

- transportation to facilities;
- availability of child care;
- clinic hours of operation;
- linguistic or cultural barriers;
- health literacy barriers;
- patients' health care beliefs;
- patients' living conditions/environmental concerns.

The committee should always look for system problems that affect the incidence of preventable hospitalizations (e.g., unavailable community resources, inadequate quality of care, lack of care coordination among providers, integrated delivery system inefficiencies). The form shown in **Figure 2** can be used by the committee to document review findings and suggestions for improving the system of care.

Reducing the level of preventable rehospitalizations will require implementation of several different action plans. To effect changes in lifestyle and health behaviors, consumers must have an interaction with the primary care system — meaning that access problems must be overcome. If quality of care is found to be a problem, the committee may need to develop and disseminate practice guidelines to caregivers or encourage continuing education. If there is a question about a practitioner's compliance with the standard of care, the case should be referred for peer review by the appropriate group. The utilization management committee should not be involved in judging individual competence.

Figure 1: Ambulatory Care Sensitive Conditions*

Pediatric
- Perforated appendix
- Pediatric asthma
- Dehydration
- Bacterial pneumonia
- Urinary tract infection
- Pediatric gastroenteritis

Adult
- Perforated appendix
- Adult asthma
- Dehydration
- Bacterial pneumonia
- Urinary tract infection
- Chronic obstructive pulmonary disease
- Hypertension
- Angina without procedure
- Congestive heart failure
- Short-term diabetes complications
- Long-term diabetes complications
- Uncontrolled diabetes
- Lower extremity amputation in diabetic patients

* Excludes transfers from other facilities, pregnancy, childbirth, newborn, and neonates.

Two cases reviewed

Following are two summaries of readmission cases reviewed by a hospital's utilization management committee. Through evaluation of inpatient and outpatient records, as well as input from caregivers, the committee discovered some opportunities for improvement. Often the tactics needed to reduce preventable hospitalizations require action by outpatient providers. Thus, it is important that these providers are supportive of the readmission review process and invited to be involved in the case discussions.

- **Readmission for hypertension:** Home health record shows that the patient reportedly experienced symptoms possibly associated with hypertension. Despite nurses' recommendations, patient did not seek treatment. **Action:** Evaluate patient's

access to care and reduce barriers. Initiate more intensive patient and family education through home health agency or outpatient case manager.

• **Readmission for uncontrolled diabetes:** Clinic records show that appropriate lab tests were done but abnormal results were not followed up. **Action:** Evaluate continuity of care between nurse practitioner and primary care physician. Identify where the communication system broke down and implement improvements.

Medicare's payment policies are changing. Hospitals will increasingly be rewarded for efficient use of resources across the continuum of care. One way to stay ahead of these changes is to involve case managers in identifying and analyzing preventable hospitalizations. By working closely with post-hospital providers, case managers can assist in examining the causes of readmissions and begin now to minimize the influence of controllable factors. ■

Figure 2: Case Review Form

Patient ID#: _____ **Admission date:** _____ **Discharge date:** _____

Condition resulting in patient's hospitalization: _____
Date(s) of last hospitalization:_____
Date(s) patient seen in clinic prior to hospitalization: _____
Date of last home health visit: _____
Patient's primary physician: _____
Patient's home health provider: _____
Outpatient case manager:_____
Other outpatient providers: _____

Review Criteria

	Yes	No	N/A
In last hospitalization, did the patient appear stable and ready for discharge?	___	___	___
In last hospitalization, was discharge plan appropriate to the needs of the patient?	___	___	___
Following last hospitalization, was recommended discharge plan implemented?	___	___	___
Do post-hospital records indicate that caregiver(s) recognized the potential for problems that ultimately required the patient's hospitalization?	___	___	___
Was outpatient management (tests, interventions, etc.) appropriate to the clinical needs of the patient?	___	___	___
If patient did not follow recommended plan of care, did caregiver(s) note follow-up plans to educate/change behavior or situation?	___	___	___
Did lack of access to health care services contribute to the patient's hospitalization?	___	___	___
Did a breakdown in the continuity of care contribute to the patient's hospitalization?	___	___	___

In retrospect, what could have been done to aid in the prevention of this hospitalization?_____
_____
_____

Reviewer: _____ Date of review: _____

Source of both charts: Brown-Spath & Associates, Forest Grove, OR.

AMBULATORY CARE
QUARTERLY

Respiratory section added to Standard Precautions

Updated CDC guidelines also address SARS

Under updated infection control guidelines from the Centers for Disease Control and Prevention (CDC), Standard Precautions now include respiratory/cough etiquette instructions.

The transition of health care delivery from primarily acute care hospitals to other health care settings, including freestanding ambulatory surgery centers, created a need for recommendations that can be applied in all health care settings using common principles of infection control practice, yet can be modified to reflect setting-specific needs.

"The biggest concern with an ambulatory surgery center is that the individual patient doesn't know they have the infection, nor does the ambulatory surgery personnel," says **Joan Blanchard**, RN, MSS, CNOR, CIC, perioperative nursing specialist at the Center for Nursing Practice at the Association of periOperative Registered Nurses (AORN) in Denver. Blanchard served as the liaison from AORN to the Healthcare Infection Control Practices Advisory Committee (HICPAC), which developed the guidelines.

In ambulatory surgery, you don't have the patient under observation for long afterward and may not know if your efforts at infection control prevention have been successful, says **E. Patchen Dellinger**, MD, professor and vice chairman of the department of surgery and chief, division of general surgery, at the University of Washington in Seattle. Dellinger also served on HICPAC. "You may not have same awareness of what's going on" as inpatient providers, he says. "You may not know if the infection control issues are not being adequately dealt with."

The CDC's respiratory/cough etiquette guidelines grew out of the 2003 outbreaks of severe acute respiratory syndrome (SARS), which indicated a need for infection control measures at the first point of encounter in a health care setting, such as the reception desk of outpatient facilities and physician offices, the guidelines say. The strategy targets patients, family members, and friends with an undiagnosed respiratory infection that can be transmitted, and it applies to any person showing signs of illness, including cough, congestion, rhinorrhea, or increased respiratory secretions when entering a facility.

Components of the respiratory/cough etiquette

CNE *questions*

9. The Joint Commission instituted patient flow standards beginning in ___.
A. 2000
B. 2006
C. 2005
D. 1999

10. Improving communication between case managers and the nursing staff at North Broward Medical Center decreased the turnaround time for patients being discharged to home by ____.
A. 1.5 hours
B. four hours
C. 2.5 hours
D. three hours

11. According to Charlotte Thompson, RRT, BA, MBA, case managers should be excluded from the team that works on patient throughput.
A. True
B. False

12. Which of the following "ambulatory care sensitive conditions" pertain to pediatric patients?
A. Dehydration
B. Urinary tract infections
C. Perforated appendix
D. All of the above

Answer key: 9. C; 10. A; 11. B; 12. D.

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

guidelines include:

- Education of facility staff, patients, and visitors.
- Posted signs in languages appropriate to the population served, with instructions to patients, family members, and friends. Signs can be posted at the entrance of the facility or at the reception/registration desk asking that people who have symptoms of a respiratory infection, such as cough, flu-like illness, or increased respiratory secretions, inform the receptionist. You also can add the presence of diarrhea, skin rash, and known or suspected exposure to a transmissible disease such as measles, pertussis, chickenpox, or tuberculosis.
- Source control measures, such as covering the mouth/nose with a tissue when coughing and prompt disposal of used tissues, using surgical masks on the coughing person when tolerated and appropriate. The CDC guidelines acknowledge that masking is difficult in some situations, such as in pediatric settings, "in which case, the emphasis by necessity may be on cough etiquette."
- Spatial separation, ideally more than 3 feet, of people with respiratory infections in common waiting areas, when possible. Immediately placing potentially infectious people in an examination room limits exposure in common waiting areas, the CDC points out.
- Hand hygiene after contact with respiratory secretions.

Hand hygiene is one of the biggest challenges in health care, Dellinger says. Outside of the operating room, "health care professionals are in a hurry and tend not to follow through," he says.

When examining and caring for patients with signs and symptoms of a respiratory infection, wear a mask and use hand hygiene, the CDC guidelines recommend. "Health care personnel who have a respiratory infection are advised to avoid direct patient contact, especially with high-risk patients," the guidelines say. "If this is not possible, then a mask should be worn while providing patient care."

Other changes to the Standard Precautions are safe injection practices, including the use of a mask when performing some high-risk, prolonged procedures involving spinal canal punctures, such as myelography and epidural anesthesia. These recommendations grew out of continued outbreaks of hepatitis B and C in ambulatory settings, according to the CDC. The need for a mask was added due to recent evidence of an associated risk for developing meningitis caused by respiratory flora, the CDC says.

Guidelines issued on SARS

Another change to the CDC guidelines is the addition of a section on SARS.

Exposure to aerosol-generating procedures, such as endotracheal intubation and suctioning, has been associated with transmission of infection to large numbers of health care staff outside the United States, the CDC points out. Therefore, aerosolization of small infectious particles generated during such procedures could be a risk factor for transmission to others in a multi-bed room or shared airspace, the CDC says.

The CDC recommends detecting cases early by screening persons with symptoms of respiratory infection for their travel history to areas experiencing community transmission of SARS and for contact with SARS patients. Also, follow respiratory hygiene/cough etiquette by placing a mask over the patient's nose and mouth, and separate those people from other patients in common waiting areas. The CDC also recommends Standard

CE objectives

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

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■

COMING IN FUTURE MONTHS

- How to train the ED staff on admissions criteria
- Strategies for implementing the Notice of Hospital Discharge Appeal Rights
- Case management that extends beyond the hospital walls
- Collaboration between case managers and social workers

Precautions, with an emphasis on hand hygiene; contact precautions, with an emphasis on environmental cleaning; airborne precautions, including fit-tested N95s or higher-level respirators approved by the National Institute for Occupational Safety and Health; and eye protection.

In another change, the CDC is replacing the term "nosocomial infections" with "health care-associated infections" to reflect the changing patterns in health care delivery and difficulty in determining the geographic site of exposure to an infectious agent and/or acquisition of infection. (The guidelines can be accessed at www.cdc.gov/ncidod/dhqp/gl_isolation.html.) ■

Corrections

The following disclosure information was inadvertently omitted from the July 2007 issue. Guest Columnist **Beverly Cunningham** reports no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Guest Columnist **Jolynne Carter** reports that she is a stockholder in ParadigmHealth Corp.

In the July 2007 issue of *Discharge Planning Advisor,* the graph from the Center for Case Management had some errors and was missing footnotes. Please visit **www.cfcm.com** and select "Resources" and then "Seminars" to view a correct version of this graph. We apologize for the errors. ■