

Reducing readmissions: Case management's critical role

Interventions that strengthen your DP efforts

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Since case management's entry into the acute care setting in the mid-1980s, most of the significant changes in health care delivery have been associated with changes in healthcare's reimbursement structure. It was true for length of stay, cost per case, quality indicators including core measures, and so on. The same is now true for readmissions. While hospitals have always considered readmissions a negative quality indicator, the real emphasis on reducing their numbers has come as a result of the pending reimbursement reductions announced by the Centers for Medicare & Medicaid Services (CMS). Once again, as many times before, this change in the reimbursement scheme has provided an opportunity for case management.

As case managers, we must ask ourselves what role we can play in reducing the number of times our patients return to our hospitals within 30 days or less. The reasons for readmissions are multifactorial, but each department of case management needs to understand its own causes and how to address them. Some of these causes are within our control, while others may be attributed to issues in the community. In either case, case managers can reach beyond the hospital walls and work directly with their community partners including home care, clinics, physicians, nursing homes, and others.

As CMS moves toward bundled payments and bundled payment reductions, these partnerships have never been more important. So ask yourself the following questions:

1. Which diagnoses contribute to the greatest number of readmissions?
2. What setting did these patients return from?
3. In what time frame do the majority of readmissions occur?

You may need to develop a data management structure if you do not currently have a case management software program to help collect this information. The data can become part of your monthly case management report card. The readmission rates should be reported as percentages. For example, what percentage of all your readmissions were due heart failure, pneumonia, or acute MI?

The literature reports that the top reasons for readmissions include the following:

- The patient did not see his or her physician within 7-10 days of discharge.
- The patient did not accurately follow his or her medication regimen once discharged to home.
- The patient was confused about how to manage his or her disease process in the home setting.
- No home care was arranged for the patient after discharge.

The causes of any one of these issues probably involves hospital processes as well as the process of transitioning the patient to the home or other setting. Because of this, case managers are in a unique position to ensure that the patient moves smoothly and safely to the next level of care. One of the most effective ways to accomplish this is to be sure that every patient is assessed for discharge planning purposes. Singling out only specific types of patients for a case management assessment will undoubtedly result in home care-eligible patients being missed, thereby increasing their statistical chances for readmission.

Many states are planning, or have implemented, readmission payment reductions for their Medicaid programs. While planning to reduce your readmission rates for Medicare, you should also be sure you understand your state's specific metrics as they pertain to changes in reimbursement for readmissions under the Medicaid program. For Medicare, you can currently obtain your hospital-specific readmission rates for heart failure, pneumonia, and acute MI by visiting the CMS website www.hospitalcompare.gov. This site provides your specific hospital's rates and tells

you whether you are within the normal range or have room for improvement. For Medicaid, you can probably get your ranking from your state's department of health.

As you track and trend your readmission rates, it is helpful to break them out by payer. Since reimbursement will be affected by these rates, you will need to know your patterns by payer. You also may want to track your overall rate of readmission as a case management department, and use this as a quality indicator.

In addition to partnering with home care, many hospitals experience high readmission rates from nursing homes. Many times, these patients can be managed and released from the emergency department, or can be placed in observation, thereby preventing a readmission. Observation should always be considered a strategy to avoid an unnecessary readmission. The emergency department case manager can play a key role in helping to identify these patients.

Intervention #1 — Assess every admission

Assess every patient on admission and throughout their stay. Standardize your discharge planning process by developing a case management assessment form, which includes all relevant data sets needed to make a comprehensive determination as to what services the patient will need once discharged from the hospital. Then be sure that the patient is reassessed daily or as frequently as possible. This reassessment can be accomplished on daily walking rounds, when the case manager can discuss the current clinical issues as well as transitional care needs without adding any additional time to the process. It is during these assessment points that the case manager can ensure that the best plan is being developed for the patient's next level of care.

Do not underestimate the importance of this assessment process. It is the foundation from which all case management interventions for the hospital stay stem. Not only does it provide the information needed for the discharge plan, but it also provides the information for planning the hospital stay and identifying throughput delays that may need to be facilitated. The data collected are also integral to the clinical review provid-

ed to the third-party payer. Data collected once for multiple purposes is efficient and has been proven to provide the best time-management technique for the case manager.

Intervention #2 — Review your discharge paperwork

Take some time to review the documents that you give to your patients at discharge. If you work in an automated environment, then you are more likely to be providing a higher quality of discharge instructions. If you are working in a non-automated environment, then collect and review all the discharge forms that are given to patients. You may be surprised by the legibility of the forms as well as the content. If patients are given a carbon copy of the original, it may be difficult or impossible to read. It may contain medical jargon impossible for the patient to understand. It may be too complicated or non-user-friendly. Consider reviewing the forms with representatives of the medical staff so that they can provide input and participate in completing the forms in a manner that will be more understandable to the patients and their families. The more accurate and legible information we provide to them, the greater the likelihood that they will be adherent to their home care plan.

It can be quite beneficial for patients if you are able to give them the most critical pieces of information they need for a safe discharge, knowing that there will be follow-up by community providers. Overwhelming the patient with too much information can actually be counterproductive, as they may wind up remembering nothing at all. Try to determine the top, most critical action items the patient *must* understand such as:

- prescriptions to be filled;
- equipment being delivered to the home;
- next doctor's appointment;
- any outpatient testing to be done;
- first home care visit date.

Be sure the patients and care partner can fully repeat back all these items to the discharge planner so that it can be confirmed that they understand each issue. This will enhance the likelihood of compliance. Also let them know that someone from the hospital will be calling them to be sure that their needs have been met and to answer

any questions they may have. Leaving the hospital can be a very scary transition for patients, and their anxiety may reduce their retention and ability to understand what you are teaching them. You can never repeat yourself too much!

Intervention #3 — Partner with home care

Returning the patient to his or her home environment is always the discharge plan of choice. However, many patients require home care to provide a bridge from hospital to home. This may mean as little as medication administration education, or as much as IV infusions or dressing changes. Patients with high-risk diagnoses, such as congestive heart failure, should always be considered eligible for a home care visit to review medications in the home. This simple intervention can facilitate a reduction in medication errors in the home and improve the likelihood that the patient will be adherent with the medication regimen, a major cause of readmissions.

One of the case management department's measures of success should include a goal of increasing the number of discharges referred to home care. Keep track of your numbers each month and track the types of patients being referred. The higher the percentages, the higher the likelihood that you will see a drop in your readmission rates over time.

Review the process of home care referrals with your top home care providers. Ensure that referrals can be made on weekends and off-hours and that the first nurse visit occurs the day after discharge. Those first few days are the most vulnerable period for the patient. It is during this time that patients may be confused as to what they are expected to do, what follow-up appointments they need to keep, what diet they should be on, what their activity level should be, and so on.

Do not underestimate how difficult it is to transition from hospital to home. Patients are moving from a controlled, managed environment to one in which others are taking responsibility for their care, to one in which they or their family member must manage their care. This change can be confusing or overwhelming for the patient and the caregiver. Consider this when you do your

discharge education with the patient and family. Provide clear but simple instructions.

Intervention #4 — Patient education

Avoid "drive by" discharge planning. Do not try to teach patients as they are being wheeled out of the hospital. Begin the educational process as soon as the patient is physically and emotionally ready to receive the information. This early teaching will provide you with the opportunity to replicate the education as many times as necessary. Patients will be at different levels of readiness depending on their level of pain, sedation, health literacy, anxiety, or depression.

Consider these factors when you begin the educational process. Lay out a plan that is appropriate to the patient and family caregiver. Provide the key information that they need to transition safely to home. If possible, give the home care provider an update as to what you covered while the patient was in the hospital. It is likely that most of that will need to be repeated in the home, but the home care provider will have a basis to know what information the patient has already been provided and what information needs to be reinforced. Some patients may grasp certain information more readily than others or may need to have the information repeated more than once.

Intervention #5 — Family caregiver assessment

The role of the family caregiver has become increasingly critical as patients leave the acute care setting to continue their recovery at home. Do not assume that the patient's family caregiver is fully available. He or she may not have the required time or energy that the patient may require. Whenever there is a family caregiver involved, it is a good idea to assess his or her readiness in addition to the patient's and factor that into the discharge plan. Also be sure to include the family caregiver in the educational process. What the patient may not understand or remember may be understood and retained by the family caregiver.

It can be helpful to have a standard assess-

ment form that can be used to assess the family caregiver. By using this form, you can ensure that the assessment is complete and consistently covers all needed information.

Intervention #6 — Contacting patients after discharge

Working with your home care agencies, find out what percentage of patients referred to home care refuses the service. If your percentage rate is high enough, consider calling patients discharged with home care services to ensure that they accept the service into their home. Because the home care service is such an important intervention in reducing readmissions, making a telephone follow-up call may improve your patient's compliance with home care. Work directly with the agency to monitor which patients ultimately do not receive planned-for home care services and see if you can reduce that percentage over time.

Intervention #7 — Physician post-hospital appointments

As part of the discharge planning assessment, the identification of the patient's "medical home" should be done as early in the stay as possible. This home may be a literal medical home, a primary care provider, or a clinic. If the patient does not have a care provider in the community, early identification of this need will help get the ball rolling as early after admission as possible.

Once the medical home has been established, another key intervention that case managers can perform is the development of a process to ensure that patients have an appointment with their physician or clinic after discharge. This intervention can be tricky if the patient has multiple providers. The case manager should work directly with the physician of record in the hospital to determine who the post-acute provider will be. Once that has been determined, the case manager should ensure that a timely appointment has been made with that provider. Optimally, the appointment should be within the first week after discharge.

In addition to the appointment, the case manager should ensure that the patient has a means of transportation to the appointment as well. This potential problem can be a cause of a no-show and should be carefully planned in concert with the patient and the family caregiver. Be sure that the scheduled appointment is at a time that syncs with the transportation and makes sense for the patient and his or her caregiver.

Intervention #8 — Start today!

While CMS is currently monitoring heart failure, acute MI, and pneumonia readmissions, additional diagnoses will be added over the next several years. Because your hospital's percentile ranking will be based on prior years' performance, it is imperative that you begin addressing your readmission issues now. Convene a team to begin to look at the data and the processes. See if you can determine the root causes of your readmissions, and catalog them by diagnosis. Then correlate them to their route of entry to the hospital. See if they are entering through the ED, directly from a physician's office, or some other source. Until you understand the causes, you cannot put a corrective action plan in place.

Your team members should include strong representation from the medical staff and the emergency department. These key groups will be important allies as you begin to implement your changes. Nursing department leadership should also be included. Staff nurses play an important role in patient education. Before beginning this or any other program, be sure to conduct a series of educational programs. Information shared should include why the hospital is making these changes, the data to support the needed changes, the expected outcomes, and the process changes that team members should expect to see.

Create a roll-out plan and share that with all relevant players. Report data monthly, including where the team did well and where there needs to be ongoing improvement. Planning for change is always the most likely recipe for success! ■

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