HURON

FOUR WAYS TO IMPROVE CARE DELIVERY ACROSS THE CONTINUUM

REDUCE HOSPITAL READMISSIONS AND PROVIDE QUALITY OF CARE WHILE LOWERING COSTS

By Peter Gernert-Dott

With new targets for value-based payments coming from Centers for Medicare and Medicaid Services (CMS), healthcare providers must focus on delivering better outcomes while reducing avoidable readmissions.

Once CMS starts to withhold 1% of reimbursement based on quality metrics and readmission rates, the value-based purchasing scoring will directly impact the revenue received from CMS. And as CMS goes, so do the private payers. Some hospitals may even end up seeing more financial losses based on their commercial contracts than they do from CMS. Within the bundled payment environment, the quality composite score can mean the difference between earning your reconciliation payment or not for a specific Diagnosis-Related Group (DRG).

Quality ratings scores not only impact Value Based Purchasing scores, but also Medicare Star Ratings, which means improving system performance must remain a priority for all healthcare providers. However, as the bar continues to rise, staying out of the bottom quartile becomes increasingly difficult.

Using proven clinical processes — clinical documentation improvement case management, clinical variation management and interdisciplinary rounds — can positively affect providers' Core Measures and HCAHPS and readmission rates, as well as potentially reduce the risk of incurring penalties. However, none of this is possible without an organizational commitment and resources focused on quality.

Clinical Documentation Improvement

It is no secret that getting clinicians to document all aspects of the patient condition has always been a challenge — even before there was quality reporting. Since rules change frequently and clinicians might not have the capacity to keep up with the changes, documentation isn't always complete or accurate.

That is where Clinical Documentation Improvement comes into play. Getting the documentation right is important as it drives the Case Mix Index, which in turn impacts how CMS views and measures organizations. Two important items to ensure accuracy upon a patient's admission are Severity of Illness (SOI) and Risk of Mortality (ROM). If critical elements are left out of the documentation, a patient who is in poor condition upon admission may not appear to be sick on paper. If something adverse happens to the patient while in the hospital, it would be considered unexpected, and the hospital could face penalties.

Another critical element to document is Present on Admission. If, for instance, a patient enters the hospital from a nursing home with a bed sore and it goes undocumented, the presumption is that it happened during the hospital stay, which will impact hospital-acquired condition scores.

In short, it is important to capture the right code for a patient's condition because it correctly identifies their level of illness, driving the case to the next index and forecasting an accurate length of stay.

Case Management

Hospitals that hold the view of case management as a pathway to retirement for nurses should start to re-think this. In today's value-based payment world, case managers are a critical resource for decreasing readmissions by creating effective cross-continuum care plans, making timely referrals to post-acute sites of care and improving overall care coordination and chronic disease management. As such, they should be your most talented resources.

The strategy for a solid case management department consists of having case managers who possess both the technical and clinical knowledge to ensure that the patient is placed in the right level of care on admission and who are able to effectively plan for the required transitions back into the community.

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Since patient satisfaction makes up 25% of value-based purchasing scores, case managers should begin transition/discharge planning upon a patient's admission, involving both the patients and their caregivers. Keeping all parties in the decision-making process removes any element of surprise upon discharge and reduces the chance of both a readmission and a patient and family who are not clear on post discharge next steps.

For instance, if the physician decides to send the patient home with home care and the family is not in agreement, or there is no one at home to take care of them, providers are risking readmission. Even worse, unnecessary delays in discharge can occur, putting the patient at increased risk for infection, resulting in a hospital-acquired condition. Any of these create a burden on the patient and family and create unwarranted increases in length of stay and cost.

In short, adequately resourced case management teams can manage patients' length of stay and, through a collaborative team approach, enhance the communication and coordination with the patient, family and care team.

Clinical Variation Management

Care consistency, or Clinical Variation Management, is the standardization of care around known and proven best practices from evidence-based clinical care and is applicable to all healthcare providers, but especially nursing and medical care. In other words, it is driving to a consistent care delivery model with an expected length of stay for a specific DRG.

Using congestive heart failure as an example, the Geometric Mean Length of Stay (GMLOS) states that congestive heart failure should be treated with an established set of clinical pathways and protocols, with an expected discharge of three and a half days. Following evidence-based pathways in the interdisciplinary care discussions during rounds helps to coordinate the care team around an

expected length of stay with defined milestones, helping to drive the patient toward discharge.

For example, the care pathway for a congestive heart failure dictates moving the patient from intravenous medication to oral medication after 24 hours to reduce the risk of acquiring a vascular-associated infection, which is a CMS quality penalty incident. Furthermore, if a patient stays four or five days, the extra time spent in the hospital is considered an excess length of stay — an additional cost incurred to the provider that may not be reimbursed.

Unfortunately, what happens in all too many hospitals are disparities between physicians and their treatment of any single diagnosis, which drives inconsistencies and higher costs of care. Focusing on reducing unwarranted variation by using care pathways improves quality of care and drives consistency while reducing unnecessary tests and treatments, which helps ensure patients are discharged on time.

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Interdisciplinary Rounds

If Clinical Variation Management is the established pathway for a patient's care, then interdisciplinary rounds represent a visible and practical execution of that strategy. Interdisciplinary care rounds provide the forum and opportunity for discussing each patient's plan of care, thereby ensuring that all providers are on the same page as the patient moves through their care experience (path) as efficiently and effectively as possible.

Structured and standardized interdisciplinary rounds lay out the plan for the day and the plan for the patient's stay. Included in this concise conversation (on average no more than a minute per patient) are conversations regarding the expected discharge date and plan of care.

Maintaining this process and facilitating these conversations are the responsibility of the healthcare team as a whole. In addition, it is important that the resulting plan is communicated with the patient and family on a daily basis.

Folding any care pathways into the interdisciplinary discussions can move the patient through their hospital stay in a more efficient manner and help identify hurdles or roadblocks, as well as mitigate the risks that could lead to a hospital-acquired infection or other negative outcome.

For example, not removing a Foley catheter within 24 hours could result in a catheter-associated urinary tract infection, which is considered a hospital-acquired condition. This could result in a CMS penalty. A care pathway or plan of care helps the entire clinical team stay focused and on track. Perhaps most significantly, it provides the opportunity to ask questions, such as, "Is the Foley supposed to come out on day two? Is it out? If not, why not? And how do we get it out?"

It is important to keep in mind that care pathways are only effective if they are planned for that patient's diagnosis, implemented in a structured fashion and conducted on a daily basis. Many organizations report using interdisciplinary rounds but fail to monitor, track and measure utilization and compliance. A lack of measurement, visible reporting or dashboards leads to a lack of accountability, oversight and sustainability.

Organizations should adopt a standardized method for documenting important information from rounds that will be visible to all providers involved in a patient's care. At a minimum,

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there should be a place to document the expected discharge date and follow-up items. Documenting the expected discharge date helps departments across the hospital plan for admission and discharge needs. Follow-up assignments and actions, such as testing, must be consistently tracked to ensure that items are completed in a timely manner, thereby better managing the patient's care pathway.

One of the most effective ways of maintaining interdisciplinary rounds is through the use of a rounding technology. The Huron Rounding mobile platform and software provides an easy-to-use, turnkey solution for creating, conducting, tracking and monitoring interdisciplinary rounds, as well as automating the follow-up process.
The use of technology to standardize this process accomplishes several key objectives: It builds in accountability and enables continuous process improvement, as well as helps ensure long-term sustainability.

Fitting the Pieces into the Puzzle

Healthcare providers shouldn't wait until their system falls into the bottom quartile before tackling a clinically integrated approach. Having a more coordinated approach to care will result in additional savings by being able to provide more consistent care to an entire population of patients within a DRG.

The first step toward achieving a high-quality, patient-centric care model involves asking yourself, "What are the quality goals I have for my facility or my system, and what's not working?" and "How can I tie all of this back to the bedside and really make a difference in the experience of care for my patients?"

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