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CMS Raised the Discharge Planning Bar: Are You Ready to Jump?

CMS & TJC Compliance Responsibilities for the Case Manager: Part III

Toni G. *Cesta*, Ph.D., RN, FAAN
Partner and Consultant
Case Management Concepts, LLC
East Coast Office
North Bellmore, New York

Bev Cunningham, MS, RN
Partner and Consultant
Case Management Concepts, LLC
Midwest Office
Dallas, Texas

FACULTY

Toni G. Cesta, Ph.D., RN, FAAN is a founding partner of Case Management Concepts, LLC, a consulting company that assists institutions in designing, implementing and evaluating case management models, new documentation systems, and other strategies for improving care and reducing cost. Dr. Cesta is the author of eight books, a frequently sought-after speaker, lecturer and consultant and is considered one of the primary thought leaders in the field of case management. Dr. Cesta also writes a monthly column called "Case Management Insider" in AHC Media's Hospital Case Management newsletter in which she shares insights and information on current issues and trends in case management.

Dr. Cesta has been active in the research and development of case management for over 20 years. Her research in case management has included two funded studies measuring the effects of a case management model on congestive heart failure and fractured hip patient populations, with measures of patient satisfaction, quality of life, and short and long term clinical perceptions and outcomes.

Dr. Cesta has presented topics on case management at national and international conferences and workshops. She has published extensively including the fourth edition of her book, "Nursing Case Management: From Essentials to Advanced Practice Applications," the second edition of "The Case Manager's Survival Guide: Winning Strategies for Clinical Practice" which won the AJN Book of the Year award, "Survival Strategies for Nurses in Managed Care" and her newest book: "Core Skills for Hospital Case Managers".

Bev Cunningham, RN, MS is a founding partner of Case Management Concepts, LLC. She has a 25-year deep working knowledge of case management with specific expertise in denials management, patient flow and the role of the Case Manager and Social Worker in the Case Management process. She has served as a Commissioner on the Commission for Case Management Certification and is a fellow with the Advisory Board.

Bev is also former Vice President Resource Management at Medical City Dallas Hospital where she had responsibility for Case Management, Health Information Management, Patient Access, Physician Integration and Solid Organ Transplant. Prior to her position as Vice President, Bev served as Regional Director of Clinical Effectiveness for Mercy Health Partners, Toledo, Ohio. In this role she directed the Case Management, Quality Management, and Pre-Authorization Departments. She also served eight years as a consultant, assisting hospitals in implementing, evaluating and improving their case management programs. As a Clinical Assistant Professor for the Master of Nursing Program at the University of Oklahoma, she coached students in their clinical practicums. Bev continues to mentor students in a Master's of Healthcare Administration program.

Bev is a well-known speaker in the Case Management field. Her publications include a chapter CMSA's Core Curriculum for Case Management Certification and most recently, co-author of the book, Core Skills for Hospital Case Management. Bev has a BSN from Pittsburg State University, Pittsburg, Kansas and a Master of Science, Nursing Major, from the University of Oklahoma.

OBJECTIVES

1. Explain how best to implement CoP discharge planning requirements.
2. Create a discharge planning compliance dashboard.
3. Explain new and revised case management standards, regulations, and laws put forth by CMS, TJC and the federal government.
4. Evaluate case management protocols and penalties.

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COMPLIANCE

In general, **compliance** means conforming to a rule, such as a specification, policy, standard or law. **Regulatory compliance** describes the goal that corporations or public agencies aspire to achieve in their efforts to ensure that personnel are aware of and take steps to comply with relevant laws and regulations.

Wikipedia

Cooperation or obedience: Compliance with the law is expected of all.

Dictionary.com

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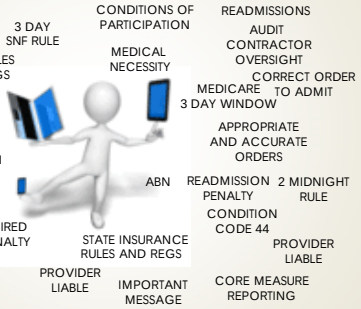
HOW CONFIDENT CAN YOU REALLY BE WITH ALL OF THE COMPLIANCE THAT IS EXPECTED?



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THE BALANCE OF COMPLIANCE: FINANCIAL AND CLINICAL

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WHO REQUIRES COMPLIANCE?

- CMS
- National and state agencies
- The Joint Commission and other accreditation bodies
- Payers
- Your hospital

CONDITIONS OF PARTICIPATION

- Written in 1983
- CMS calls them "health and safety standards"
- Identified as the foundation for improving quality and protecting the health and safety of Medicare and Medicaid beneficiaries
- Few changes since 1983 despite changes in the healthcare industry
- Revised in 2006 by the Center for Medicare and Medicaid Services (CMS)—2004 for discharge instructions
- Screening organizations are to meet or exceed these standards

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LACK OF COMPLIANCE
=
LACK OF REIMBURSEMENT

DEFINITION OF DISCHARGE PLANNING

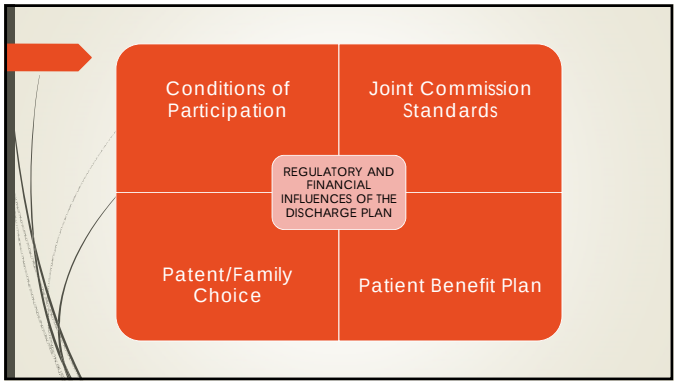
"A process used to decide what a patient needs for a smooth move from one level of care to another. This is done by a social worker or other health care professional. It includes moves from a hospital to a nursing home or to home care. Discharge planning may also include the services of home health agencies to help with the patient's home care."

Centers for Medicare and Medicaid Services, glossary definition.
www.cms.gov

FOUNDATION OF DISCHARGE PLANNING

- Interdisciplinary team involvement
- Least restrictive environment identified that can meet patient's needs
- Patient and/or family included timely in discharge planning process
- Patient and family educated about community resources that can help maintain maximum potential and independence
- Safe discharge plan established
- Patient's benefit plan will drive discharge plan, along with choice (for home health and skilled nursing facilities)

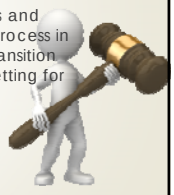
Rules and Regulations for Discharge Planning



FEDERAL REGULATIONS – SOCIAL SECURITY ACT § 1861 (ee)

Discharge Planning Process:

"The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care."



FEDERAL REGULATIONS - SOCIAL SECURITY ACT § 1861 (ee) (Cont'd)

Discharge Planning Process Standards

Hospitals must:

- Identify at an early stage of hospitalization those patients in need of discharge planning.
- Provide a discharge planning evaluation for those identified patients or upon request of patient, representative or physician.

FEDERAL REGULATIONS - SOCIAL SECURITY ACT § 1861 (ee) (Cont'd)

Discharge Planning Process Standards

Hospitals must:

- Complete evaluation on a timely basis to ensure appropriate arrangements are in place before discharge to avoid unnecessary delays in discharge.

FEDERAL REGULATIONS - SOCIAL SECURITY ACT § 1861 (ee) (Cont'd)

Discharge Planning Process Standards

Hospitals must:

- Include in evaluation patient's likely need for appropriate post-hospital services and the availability of such services.
- Include the evaluation in the patient's medical record and results must be discussed with the patient or representative.
- Arrange for the development and initial implementation of a discharge plan.

FEDERAL REGULATIONS - SOCIAL SECURITY ACT § 1861 (ee) (Cont'd)

Discharge Planning Process Standards

Hospitals must:

- Develop plan by or under the supervision of a registered nurse, social worker, or other qualified personnel.
- Consistent with Section 1802
  - Not specify or limit qualified providers
  - Identify any provider in which the hospital has a financial interest.

FEDERAL REGULATIONS - SOCIAL SECURITY ACT § 1861 (ee) (Cont'd)

Discharge Planning Process Standards: Medicare+Choice

For individuals enrolled with a Medicare+Choice organization/plan:

"The discharge planning evaluation is not required to include information on the availability of home health services through individuals and entities which do not have a contract with the organization."

"....the plan may specify or limit the provider (or providers) of post-hospital home health services or other post-hospital services under the plan."

FEDERAL REGULATIONS - SOCIAL SECURITY ACT § 1861 (ee) (Cont'd)

Applies only to patients who are admitted as inpatient. Not applicable for patients in the emergency department or outpatient, observation status.

Includes:

- Medicare and Medicaid participating hospitals
- Short-term psychiatric
- Rehabilitation
- Long-term, children's, and alcohol/drug facilities

FEDERAL REGULATIONS - SEC 482.43 CONDITIONS OF PARTICIPATION:

Discharge Planning: Standards

- Identification of needs
- Discharge planning evaluation
- Discharge plans
- Transfer or referral
- Re-assessment

www.cms.gov Hospital Conditions of Participation

CONDITIONS OF PARTICIPATION

ATTACHMENT 1

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CMS CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING 482.43

The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.

(a) Standard: Hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning

(b) Standard: Discharge planning evaluation

(1) Must provide discharge planning evaluation to patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician

(2) Registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise development of evaluation

http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr482.43.pdf

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CMS CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING 482.43

(3) Discharge planning evaluation must include evaluation of likelihood of patient needing post-hospital services and availability of the services

(4) Evaluation must include evaluation of likelihood of patient's capacity for self-care or possibility of patient being cared for in environment from which he or she entered hospital

(5) Evaluation must be completed timely so appropriate arrangements for post-hospital care are made before discharge to avoid unnecessary delays in discharge

(6) Include evaluation medical record for use in establishing appropriate discharge plan and must discuss results of evaluation with patient or individual acting on his or her behalf

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CMS CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING 482.43

Discharge plan:

(1) Registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise development of discharge plan if the discharge planning evaluation indicates need for discharge plan

(2) In the absence of finding that a patient needs discharge plan, patient's physician may request discharge plan; in such a case, hospital must develop discharge plan for patient

(3) Must arrange for initial implementation of discharge plan

(4) Must reassess discharge plan if factors may affect continuing care needs or appropriateness of plan

(5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care

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CONDITIONS OF PARTICIPATION DISCHARGE PLANNING

- The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies or outpatient services, as needed, for follow-up or ancillary care.
- The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

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CONDITIONS OF PARTICIPATION PATIENT CHOICE

- Must include in discharge plan a list of HHAs or SNFs available to patient, that participate in the Medicare program, and serve the geographic area (as defined by the HHA) in which patient resides, or in the case of a SNF, in geographic area requested by patient; HHAs must request to be listed by the hospital
  - List must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation
  - For patients enrolled in managed care organizations, hospital must indicate availability of home health and post-hospital extended care services through individuals and entities that have contract with the managed care organizations
  - Must document in medical record that list was presented the patient or the individual acting on patient's behalf

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CONDITIONS OF PARTICIPATION PATIENT CHOICE

- Hospital must inform patient or patient's family of freedom to choose among participating Medicare providers of post-hospital care services and must, when possible, respect patient and family preferences when expressed
- Hospital must not specify or otherwise limit qualified providers available to patient
- Must identify any HHA or SNF to which the patient is referred in which hospital has disclosable financial interest

IMPROVING MEDICARE POST-ACUTE TRANSFORMATION (IMPACT) ACT

- Passed by Congress September 2014
- Mandates common patient assessment data and quality measure reporting for post-acute providers
- New requirements take effect October 2016
- Requires general acute-care, critical access hospitals and post-acute care providers to meet the intent of facilitating the flow of patient information
- Sets post-acute care payments rates based on clinical characteristics of patient, rather than on setting of care

TRANSFER AGREEMENTS

A hospital and a skilled nursing facility shall have a written agreement between them for reasonable assurance that:

- "Transfer of patients will be effected between the hospital and SNF whenever such transfer is medically appropriate as determined by the attending physician."
- "There will be interchange of medical and other information necessary or useful in the care and treatment of transferred patients between institutions or to help determine if patients can be adequately cared for in either institutions."

Social Security Act § 1861 (l)

POST HOSPITAL EXTENDED CARE SERVICES 3-DAY STAY RULE

A 3-day stay is mandatory for Medicare patients that require placement in a Skilled Nursing Facility (SNF) after their hospitalization.

- Counted by # of days the patient is in an ***inpatient status*** and in his/her bed at midnight. ***Observation days do not count as part of the 3 days.***

POST HOSPITAL EXTENDED CARE SERVICES 3-DAY STAY RULE

- This rule only applies to traditional Medicare and typically not Medicare replacement policies.
- There is an additional 30-day window for qualification if not discharged directly to a SNF.
- A 3-day stay is not needed if the patient is discharged to an Acute Care Rehab or Long Term Care Hospital.

Section 1861 of the Social Security Act

Federal Regulations 10116, 10118-19 (updated clarification Medicare Benefit Policy Manual, Chapter 8, 2013)

THE FUTURE OF THE 3-DAY STAY RULE

- Medicare could waive the three-day hospital visit for skilled-nursing care with some Accountable Care Organizations
- The waver would require patients to go to nursing homes with at least three stars on Medicare's five star quality scale
- Could exclude about one-third of the nation's nursing homes that have cared for 39% of nursing residents

Modern Healthcare June 17, 2015

POST ACUTE CARE TRANSFER DRGS

A transfer DRG plays an important role in payment when a patient with a qualified DRG is transferred to a post acute provider earlier than the geometric mean LOS

If a patient is admitted with a transfer DRG and is discharged before the geometric mean LOS, the hospital is paid using a transfer formula which decreases the overall payment to the hospital

Balanced Budget Act of 1997

PREADMISSION SCREENING AND RESIDENTIAL REVIEW (PASRR)

Assessment used to ensure persons with severe mental illness and/or mental disability are identified and placed in the most appropriate settings to meet their needs

PASRR screening is needed on all patients discharging to a Medicaid certified nursing facility regardless of payer

The Omnibus Reconciliation Act of 1987 (OBRA) Federal Regulation – 42CFR 483.100 – 483.138

NOTIFICATION OF DISCHARGE APPEAL RIGHTS

Notice – Important Message from Medicare (IM)

- Explains discharge appeal rights.
- Hospitals must issue and explain IM within 2 calendar days of admission, and obtain the signature of beneficiary or representative.
- Hospitals must provide 2nd IM within 2 calendar days of the day of discharge but not routinely on the day of discharge.

Section 1154 of the Social Security Act
CMS-4105-F

NOTIFICATION OF APPEAL RIGHTS (Cont'd)

- Hospital delivers Detailed Notice of Discharge and HINN 12.
- Hospital will provide all necessary information to the QIO including medical record, IM, and Detailed Notice.
- QIO has one calendar day to make a decision after all information is received if request is timely. Two calendar days if request is untimely.

Section 1154 of the Social Security Act

CMS-4105-F

NOTIFICATION OF APPEAL RIGHTS Cont'd

After QIO review:

- QIO agrees with hospital: Beneficiary is responsible for continued stay charges beginning at noon of the day **after** QIO notification to the beneficiary.
- QIO agrees with beneficiary: No liability to beneficiary except for coinsurance and deductibles. Will need new 2nd notice and discharge order from physician.

Section 1154 of the Social Security Act

CMS-4105-F

PREPARING FOR A CMS SURVEY

- CMS finalized an updated discharge planning survey guidance for surveyors May 2013
- A CMS survey can be
  - Validation survey after a Joint Commission survey (or other accrediting body with deemed status for the Conditions of Participation—deemed status is determined by the hospital)
  - Result of a complaint or severe error
  - Random survey
- Surveyors are now surveying for the following
  - Conditions of Participation requirements and interpretive guidelines
  - Advisory boxes: "blue boxes" to promote better patient outcomes
    - "Blue boxes" not required for hospital compliance
    - Resource information for process improvements
    - Surveyors are to survey advisory boxes, but not issue citations based on these

CMS SURVEYOR WORKSHEET

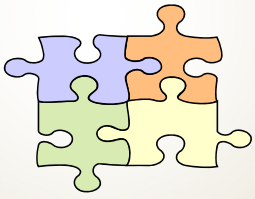
ATTACHMENT 2

CONDITIONS OF PARTICIPATION DISCHARGE PLANNING
Advisory Blue Boxes

ATTACHMENT 3

YOUR DEPARTMENT'S OPERATIONS AND THE CONDITIONS OF PARTICIPATION

Fitting Them Together



PROACTIVE DISCHARGE PLANNING

Discharge planning starts on admission

- Evaluate and coordinate discharge planning early in process to assure timely discharge
- Assessment must be done on day of admission

Include payers in discharge planning process:

- Available benefits & co-pays
- Preferred Providers
- Pre-Certification and Authorizations
- Barrier resolution

PROACTIVE DISCHARGE PLANNING ON DAY OF ADMISSION

- Promotes:
  - Customer satisfaction
    - -Patient & Family
    - -Physician
    - -Nursing
    - -Community partners
  - Improved outcomes
  - Improved patient flow
  - Reductions in LOS, delays, & denials

PROACTIVE CASE MANAGEMENT

Critical Part of the Multidisciplinary Discharge Planning Team

IDENTIFY NEEDS

Identify all patients who are likely to suffer adverse health consequences upon discharge if there is not adequate discharge planning

Federal Regulations - Sec 482.43 Conditions of Participation

IDENTIFY NEEDS

- All patients are entitled to a discharge plan.
- Upon admission, case managers should screen all patients for high risk factors; risk factors should be based on your patient population
- Daily walking rounds provide the opportunity to further identify patients for evaluation and barriers to discharge
  - Attendees should include physician, nursing, case management, and other disciplines as needed
  - Patient is an active part of walking rounds

DISCHARGE PLANNING EVALUATION

Case managers must complete an evaluation on all patients identified as needing discharge planning either through screening or request

Evaluation needs to include a comprehensive assessment

- Need for post-hospital services including the most appropriate level of care, i.e., home, home care, placement options
- Patient's capacity for self-care and whether he/she can return to their previous setting
- Evaluate the prior and current level of functioning
- Decision-making capacity
- Mental Status
- Home environment
- Family support system
- Barriers
- Availability of services
- Requires an additional assessment of resources available to the patient

DISCHARGE PLANNING EVALUATION (Cont'd)

Evaluations must be timely so that appropriate arrangements can be made

Case managers must work with the team: physicians, Nursing, and key stakeholders in ancillary departments

Discuss evaluation results with the patient and/or representative.

- In the event patient and/or representative disagrees with the evaluation/recommendations or is slow in making a decision regarding the recommendations, utilize patient/family conferences to assist in goal setting with expected outcomes
- Case Management or nursing should arrange for conference including date, time, location, participants, and documentation of action
- Conference should include patient (if able), family, physician, nursing, case management, social work, and other disciplines as needed, i.e., respiratory care, therapy, etc

DISCHARGE PLANNING EVALUATION (Cont'd)

- Communicate possible date of discharge on white board in room
- Document evaluation in the patient's medical record for use in establishing an appropriate discharge plan
- Monitor ongoing documentation of status changes and disposition

DISCHARGE PLANNING EVALUATION RESOURCE ASSESSMENT

Once the evaluation of needs is complete, the case manager must identify resources available to the patient.

Includes:

- Human resources: Availability of a caregiver, i.e., family and friends
- Community-based resources
- Financial resources

DISCHARGE PLANNING EVALUATION COMMUNITY–BASED RESOURCES

- Home Health Care (HHC)
- Private Duty
- Hospice Care
- Durable Medical Equipment (DME)
- Acute Care Hospital Transfers
- Acute Rehabilitation Hospitals
- Long Term Acute Care Hospitals (LTACHS)
- Skilled Nursing Facilities (SNF)
- Extended care placement (ECF custodial)
- Assisted living Facilities (ALF)
- Outpatients services (Ex: Rehab, IV Therapy, Dialysis)
- Other Community resources
- Transportation

DISCHARGE PLAN

RN, SW or other qualified professional must develop or supervise the development of a discharge plan if the evaluation indicates a need for such plan.

DISCHARGE PLAN (Cont'd)

The RN Case Manager and/or Social Worker Must:

- Arrange for the initial implementation of the plan
- Reassess if conditions change (for example: unexpected transfer to ICU or unexpected surgical procedure
- As needed, counsel the patient and/or representative to prepare them for discharge
- Document all interventions and the patient's consent to the plan in the medical record

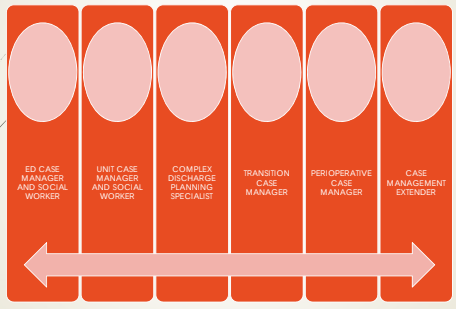
BARRIERS TO DISCHARGE PLANNING

Sometimes, it's like pulling a rabbit out of your hat!

COMMON BARRIERS

- Acuity
- Age
- Bariatric Issues
- Bed Availability
- Behavior/Restraints
- Finances
- Patient/Family
- Physicians
- Lack of Resources
- Advanced Directives/DNR paperwork
- Abuse and Neglect
- Homeless
- Legal
- Transportation
- Undocumented Immigrants
- Incompetency Issues - Guardianship

CRITICAL CASE MANAGEMENT POSITIONS FOR EFFECTIVE DISCHARGE PLANNING



DISCHARGE PLANNING DASHBOARD METRICS

- % of patients with timely discharge plan
- % patients with discharge plan re-evaluated, as appropriate
- % of patients discharged to home health with choice documented in medical record
- % of patients discharged to a skilled nursing facility with choice documented in medical record
- % of patients with required PASRR
- % of patients with second Important Message
- % of patients with timely second Important Message
- % of patients transferred to SNF without 3-day qualifying stay (as inpatient)
- % of patients discharged with complaints about their discharge planning

RESOURCES

- Balanced Budget Act of 1997
- Centers for Medicare and Medicaid Services (CMS)
  - www.cms.gov
  - Glossary
  - CMS – 4105F
- Federal Regulations
  - Sec 482.43, Hospital Conditions of Participation
  - Sec 10116, 10118-19
  - 42 CFR 483.100- 483.138
  - 42 CFR 411,424
  - 42 CRR 417.23 (b)2
- Social Security Act – section 1861
  - http://www.ssa.gov/OP_Home/ssact/title18/1861.htm
- The Omnibus Reconciliation Act of 1987 (OBRA)

RESOURCES

- Social Security Act – section 1802 Freedom of Choice
  - http://www.ssa.gov/OP_Home/ssact/title18/1802.htm
- Hospital Regulations for 3 day inpatient to qualify for SNF
  - http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R161BP.pdf
- PASARR Screening
  - http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Preadmission-Screening-and-Resident-Review-PASRR.html
- Important Message from Medicare: Discharge Appeal Rights
  - http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html
- Center for Medicare Advocacy: Discharge Planning
  - www.medicareadvocacy.com

RESOURCES

- American Hospital Association
  - Private-Sector Hospital Discharge Tools (Sample hospital discharge tools that strive to improve transitions to post-acute care and reduce admissions) January 2015
- CMS Revision to State Operations Manual Appendix A – Interpretive Guidelines for 42 CFR 482.43, Discharge Planning May 17, 2013
- Medicare Learning Network: Discharge Planning
- CMS: Your Discharge Planning Checklist (For patients and caregivers preparing to leave a hospital, nursing home or other care setting) www.medicare.gov
- Caregiver Action Network www.caregiveraction.org
- Family care givers www.caregiving.com

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Thanks for attending!! Questions??

Bev Cunningham
BEVCMC@HOTMAIL.COM

Toni Cesta
CESTACON@AOL.COM