HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

APRIL 2015 Vol. 23, No. 4; p. 41-52

INSIDE

AHC Media

The RACs are back: Auditors to start performing complex reviews

New contracts, new rules are still in limbo

After almost a year's reprieve, hospitals can expect to begin getting records requests from Recovery Auditors as the program goes into full swing again.

The Centers for Medicare & Medicaid Services (CMS) temporarily suspended the program in February 2014 "to allow CMS to refine and improve the Recovery Audit Program," according to a news release issued at the time.

The auditors have been performing automated reviews since last summer and, beginning April 1, can perform complex patient status reviews, says **Kurt Hopfensperger**, MD, JD, senior medical director for Executive Health Resources, a Newtown Square, PA, healthcare consulting firm.

In early 2014, CMS announced plans

EXECUTIVE SUMMARY

The Recovery Auditor program is cranking back up again after almost a year's hiatus, but despite the Centers for Medicare & Medicaid Services' plans to improve the program and issue new contracts, the audits will be conducted by the same auditors under the same rules.

- Auditors are likely to target short stays and other weak areas the Medicare Administrative Contractors identified during Probe and Educate, according to Elizabeth Lamkin, MHA, chief executive officer and partner in PACE Healthcare Consulting, LLC, based in Beaufort County, SC.
- CMS has not made any clarifications to the two-midnight rule, and auditors may begin auditing hospitals for compliance beginning April 1.
- The Outpatient Prospective Payment System (OPPS) final rule clarified the requirement for physician certification, saying that the order to admit must be signed by the treating physician and the justification for the admission, the expected length of stay, the treatment plan, and the discharge plan do not have to be a separate document but can be part of the history and physical.

Financial Disclosure: Executive Editor **Russ Underwood**, Associate Managing Editor **Jill Drachenberg**, and Editor **Mary Booth Thomas**, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Nurse Planner **Toni Cesta**, PhD, RN, FAAN, Consulting Editor of Hospital Case Management, is a consultant with Case Management Concepts LLC.

HOSPITAL CASE MANAGEMENT

Hospital Case Management™,
ISSN 1087-0652, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
Hospital Case Management
P.O. Box 550669
Atlanta, GA 30355.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
customerservice@ahcmedia.com.
www.ahcmedia.com
Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year (12 issues) with free Nursing Contact Hours or CMCC clock hours, $519. Add $19.99 for shipping & handling. Online only, single user: 1 year with free Nursing Contact Hours or CMCC clock hours, $469.

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Back issues: $78. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.
GST Registration Number: R128870672.

ACCREDITATION: AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 18 clock hours.
The target audience for Hospital Case Management™ is hospital-based case managers. This activity is valid 24 months from the date of publication.

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to revamp the Recovery Audit program in response to industry feedback and issue new contracts with audits starting under the new program in Jan. 1, 2015. The agency made changes to the program and started to rebid the Recovery Audit contracts. However, the process has been held up by a lawsuit filed by a contractor who challenged the payment terms that prohibit an auditor from being paid until after the claim has cleared the second level of appeals, according to **Elizabeth Lamkin**, MHA, chief executive officer and partner in PACE Healthcare Consulting, LLC, based in Beaufort County, SC. *(For information on the Recovery Auditor program changes, see page 44.)*

Until the new contracts are issued, hospitals will be audited by the same RAs, operating under the same rules, Hopfensperger says.

"In 2015, proving medical necessity is still very important, and documentation must contain evidence-based, objective information that the services provided the patients are necessary. Hospitals must have a robust utilization review process in place. They should still use screening tools and have a review on a second level by a physician advisor if there are any questions," he says.

Lamkin predicts that auditors are likely to go after short stays and look for medical necessity and other weak areas uncovered by the Medicare Administrative Contractors (MACs) during Probe and Educate and by The Comprehensive Error Rate Testing (CERT) program, which CMS developed to measure improper payments. These include cardiac procedures and total joint replacement surgery, she adds.

The Medicare Fee for Service Improper Payments Report supplemental appendices list the Top 20 Service Types with the Highest Improper Payments for Inpatient Hospitals for Medicare Part A as determined by the CERT program.[1] The top five diagnoses are chest pain; cardiac defibrillator implant without cardiac catheterization; permanent cardiac pacemaker implant; circulator disorders, except AMI, with cardiac catheterization; and peripheral vascular disorders. The majority of problems included insufficient documentation, medical necessity, and incorrect coding, Lamkin says.

She recommends that case managers review the information in the report and analyze their hospital's Program for Evaluating Payment Patterns Electronic Report (PEPPER) to identify the highest opportunities for the RAs and focus on improving in those areas.

"Hospitals should conduct an ongoing analysis of denials and the reason for them. The CERT report is a general list. Each hospital may be different. Case managers should be evaluating the areas that need improvement in their own hospitals," she says. In addition, case managers should adhere to the Medicare Inpatient Only List and use it as a defense to denials. Lamkin also recommends that hospitals appoint a committee to stay on top of all regulatory changes so everyone will be prepared and understand the areas of risk.

"Hospitals have to get everything right on the front end so there won't be any problems on the back end," Lamkin says.

CMS is winding down the Medicare Administrative Contractors Probe and Educate initiative but has made a major change, Hopfensperger says. When the Probe and Educate program began, if a hospital had a high error rate in the first two Probe and Educate audits, the MACs could request 10 times the original number of charts. CMS has announced that the third audit will call for the same number of

charts as the MACs originally requested, Hopfensperger says.

Many hospitals did not improve when they underwent expanded reviews under Probe and Educate, says **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services, a Shawnee, OK, healthcare consulting firm.

"The MACs found easy things to deny like the admitting physician didn't sign the admission order prior to discharge. Case managers need to review documentation for short-stay patients in particular to make sure the physicians have clearly documented the medical necessity of services ordered and the need for continued care in the hospital setting," she adds.

The language of the Inpatient Prospective Payment System final rule for fiscal 2014 was interpreted by some to require a certification statement that was duplicative of medical record content, Hale says.

"In the 2015 Outpatient Prospective Payment System (OPPS) final rule, CMS clarified that it was not looking for a separate certification form. The essence is, certification is achieved by a signed inpatient order and the usual content of the medical record should clearly describe the reason for the admission, the plan of care, and an individualized estimated length of stay and the discharge plan should be in the medical record," Hale says.

Case managers can protect payment to the hospital by making sure the inpatient order is signed by the physician responsible for the admission of the patient to the hospital. The remainder of the certification requirement should be in the history and physical, progress notes and discharge summary, she says.

If case managers take a verbal order from physicians, they should make sure it's signed before the patient is discharged and that the medical record includes the reason why the physician expected the patient to be in the hospital for two midnights or longer, says **Joanna Malcolm**, RN, CCM, BSN, consulting manager, Clinical Advisory Services for Pershing, Yoakley & Associates in Atlanta.

CMS has made it clear that only the physician can determine patient status, Malcolm points out. "Case managers should not be determining the status but they can assist the physicians by providing criteria and regulations in order to help the physician determine the status, and ensure that physicians sign the admission order and write the reason they think the patient will be in the hospital for two midnights. They should make sure that the physician is specific about why they are admitting patients and that the order says 'admit to inpatient.' Case managers need to make sure the physicians become accustomed to writing why the patient is going to be admitted in clear, concise language," she says.

"If hospitals and physicians don't have a clear understanding of the regulations and criteria, it could be financially devastating," Malcolm adds.

"It all comes down to being consistent about admissions and ensuring that the documentation is complete and accurately represents the condition of the patient and the services provided so that the hospital can

AHA seeks delay of two-midnight rule

The American Hospital Association (AHA) has asked the Centers for Medicare & Medicaid Services (CMS) to delay enforcement of its controversial two-midnight policy until Oct. 1, 2015, or until the agency develops and implements a short-stay payment policy, whichever comes later.

In a letter to Sean Cavanaugh, deputy administrator and director of CMS, Linda E. Fishman, AHA's senior vice president for public policy, analysis, and development, stated that "the two-midnight rule results in inadequate reimbursement to hospitals for beneficiaries who require an inpatient level of care, but who stay in the hospital less than two midnights."

The two-midnight rule was intended to give hospitals guidance on what constitutes an inpatient admission and what is outpatient with observation services, but instead has caused confusion and controversy and even prompted the U.S. Congress to intervene.

In the spring of 2014, as part of a bill to stave off cuts to Medicare physician payments, Congress delayed post-payment audits of the two-midnight rule until March 31, 2015, to give CMS time to issue guidance on the rule and to develop a payment system for short stays.

In the Inpatient Prospective Payment System proposed rule for fiscal 2014, CMS said it was looking for ways to identify short stays and alternatives for paying for short stays, but it didn't put forth a proposal in the final rule and, so far, has not issued further guidance on the two-midnight rule or announced a policy to address short-stay patients who need inpatient services but don't need to be in the hospital over two midnights. ■

meet goals and receive the appropriate reimbursement for the services they provide," she says.

It's more important than ever for case managers to develop a close working relationship with physicians and communicate with them regularly, especially when it comes to patient status and documentation, she adds.

CMS is giving more scrutiny on outliers, Lamkin says. "Case managers and physicians need to work together to understand continued stay criteria and monitor patients closely every day," she says.

"Utilization management is getting more and more important. The utilization management committee should create scorecards to help the frontline staff understand the patient population," Lamkin says. She suggests monitoring the length of stay for inpatients and observation patients, tracking the percentage of observation patients and inpatients, the percentage of patients who meet medical necessity criteria, and other patient population data.

Look for patterns and use the data to develop performance improvement projects, she suggests.

Preparation for the recovery audits isn't the only reason case managers should make sure that the documentation is detailed and accurate, Hopfensperger says.

Hopfensperger warns hospitals to prepare for the impact of Transmittal 541, which directs auditors, particularly the Medicare Administrative Contractors, to take back surgeons' fees if a hospital case is denied for not being reasonable and medically necessary.

"Transmittal 541 means that if a surgeon's documentation does not support the need for the procedure and the hospital's inpatient claim is denied, the auditors can take back the surgeon's professional payment in addition to taking back the hospital's payment. This can have a huge impact on hospitals that employ a large number of surgeons," he says.

It is very important for surgeons to understand that they must document thoroughly, Hopfensperger says. "We know that the auditors have been denying some orthopedic cases for lack of documentation. This is more generalized and broader and gives them the ability to take back the surgeon's payments as well as the hospital's," he says.

Case managers should take an active role in helping physicians make sure their documentation is complete and accurate and supports the need for the surgery and the impatient stay, he says.

The HHS Office of the Inspector General is cracking down on cardiac procedures in part because of feedback from whistle-blowers, Malcolm says.

"They're focusing on those big procedures that cost a lot and taking back money from the hospitals," she says.

"Case managers should review the cases before the procedures and make sure they comply with Medicare regulations. This is another example of why documentation is so important. Case managers should ensure that the documentation for cardiac procedures is accurate and complete and that medical necessity for the procedures is documented," she says. ■

REFERENCE

1. http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/Downloads/AppendicesMedicareFee-for-Service2014ImproperPaymentsReport.pdf?agree=yes&next=Accept

Changes in RA program are intended to reduce burden on providers

Provisions will be effective when new contracts are issued

The Centers for Medicare & Medicaid Services (CMS) has announced a number of changes to the Recovery Audit program that will become effective when each new contract is issued. The process to rebid the contracts has been halted because of a lawsuit by a contractor, according to **Elizabeth Lamkin**, MHA, chief executive officer and partner in PACE Healthcare Consulting, LLC, based in Beaufort County, SC.

The announcement issued by CMS states that the changes were made in response to concerns about the program raised by the healthcare industry and that the changes are expected to result in "a more effective and efficient program, by enhanced oversight, reduced provider burden, and more program transparency."

Here are some of the changes mentioned in the announcement:

• Providers that comply with Medicare rules will have fewer Recovery Audit reviews. Additional document requests will be lower for providers with

lower denial rates and will be adjusted as a provider's denial rate decreases. Currently, the additional document request limits are the same for providers of a similar size.

• If a hospital submits a claim for an inpatient stay within three months of the date of service, the recovery auditors will have only six months from the date of service to review the claim for patient status. This is a change from a three-year look-back period.

• Under the new rules, recovery auditors will have 30 days to complete complex reviews and notify providers of their findings, instead of the current 60 days.

• Recovery auditors will not receive a contingency fee until after the second level of appeal is exhausted. The current rules call for the RAs to be paid immediately on denial and recoupment of claims.

• The recovery auditors will be required to have less than 10% of their denials overturned at the first level of appeal, not including claims that were denied due to no or insufficient documentation or claims that were corrected during the appeals process. RAs that have a higher overturn rate will be placed on a corrective action plan that may include decreasing the additional document request limits or stopping certain reviews until the problem is corrected. The current program has no penalties for high appeal overturn rates.

• Recovery auditors will have to maintain an accuracy rate of at least 95% on automated reviews or face a progressive reduction in limits on additional document requests.

• CMS has established a provider relations coordinator that providers can contact when issues arise that aren't resolved by discussions with the recovery auditor.

• CMS is considering developing a provider satisfaction survey to obtain feedback on the performance of recovery auditors.

To read the CMS announcement on the new rules, visit http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf. ■

Game changer: HHS sets goals for basing payments on quality

Edict puts case management in the spotlight

The U.S. Department of Health and Human Services' (HHS) announcement of goals to tie Medicare fee-for-service payments to quality or value is a game-changer that will impact every case manager across the nation and make the case management role critically important throughout the continuum of care, according to **Andy Ziskind**, MD, managing director at Huron Consulting, a Chicago-based healthcare consulting firm.

"CMS has been introducing payments based on metrics and quality scores. Now, they will dominate the Medicare payment system. At a high level, this is going to accelerate all the changes that hospitals and health systems need to make to deliver care to patients efficiently throughout the continuum. The focus on quality and value-based payments raises the importance of the care manager," he adds.

In January, Health and Human Services Secretary Sylvia M. Burwell announced a goal of tying 85% of all Medicare fee-for-service payments to quality or value by the end of 2016 and 90% by the end of 2018 through initiatives such as the Value-based Purchasing Program and the Hospital Readmission Reduction Program. She also announced a goal of making 30% of fee-for-service Medicare payments through alternative payment models such as bundled payment arrangements and accountable care organizations by the end of 2016 and making 50% of payments through these models by the end of 2018.

CMS is already basing a portion of reimbursement on quality in the Value-based Purchasing Program, the Hospital Readmission Reduction Program, and the Hospital-Acquired Condition (HAC) Reduction Program, Ziskind points out. Alternative payment models currently account for about 20% of Medicare payments, but this is the first time there have been specific goals to aggressively increase tying Medicare payments to performance, he adds.

Ziskind anticipates that commercial payers will follow Medicare's lead and expand their own programs to base payments on quality measures.

"The emphasis on quality means that hospitals have to find ways to make sure they are delivering the services that patients want and that CMS expects," says **Elizabeth Lamkin**, MHA, chief executive officer and partner in PACE Healthcare Consulting, LLC, based in Beaufort County, SC.

Rounds are the best way to

understand what is going on in the hospital and what is going on with patients, Lamkin says. "Leadership rounds are essential so hospital leaders will understand what is working, what is not, and what changes need to be made so patients can get what they need. This is good for quality measures, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores, and patient satisfaction," she says. Nursing rounds and nurse manager rounds also are crucial, she says.

"Multidisciplinary rounds are important for value-based purchasing scores and for patient throughput," she adds.

The biggest thing case managers can do is make sure the plan of care and discharge information is clearly articulated, Lamkin says.

With the increasing emphasis on value-based purchasing and other quality-based initiatives, complete and detailed documentation takes on new importance, says **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services, a Shawnee, OK, healthcare consulting firm.

The outcomes scores for value-based purchasing are based on risk-adjusted data, and documentation needs to reflect the patient's diagnosis in very specific terms based upon clinically supported data in the medical record, she points out.

"The Complications and Comorbidities (CCs) and Major Complications and Comorbidities (MCCs) are important for reimbursement, but even if they are well documented, a hospital still may be in a bad position when it comes to risk adjustment if there are other conditions that are not documented," she says.

CMS uses the hierarchical condition classification (HCC) system for risk adjustment in the value-based purchasing program, Hale says. "Hospitals are not likely to fare well when it comes to mortality rates, readmissions, patient safety indicators, and cost-per-beneficiary ratios if they don't understand the hierarchical condition classification system and ensure that every condition the patient has is documented and reported according to Official Coding Guidelines," she says.

CMS developed the HCC model as a risk-adjustment model to determine payments for the Medicare Advantage program, Hale says. The model identifies individuals with serious or chronic illnesses, using ICD-9 codes, and assigns a risk category based on the individual's conditions and demographic factors.

"This system helps CMS give hospitals and physicians credit for severity of illness. CMS expects the sickest patients to have more frequent readmissions, incur greater costs, and expire more frequently. However, documentation must support the condition and the physician's assessment and treatment plan," Hale says.

"It all folds into clinical documentation improvement and an awareness on the part of the clinical documentation improvement staff, the coding staff, and physicians. CMS has allowed hospitals to report up to 25 diagnoses, but the documentation has to match up," Hale says.

Clinical documentation improvement programs should be about more than just coding and finding better ways to identify comorbidities, Lamkin advises. "Clinical documentation staff should help physicians navigate the electronic medical record," she says. For instance, if there is a physical therapy note or a lab value that the physician needs, make sure he or she saw it and reacted.

Lamkin suggests that hospitals consider moving clinical documentation improvement to care management or the quality department. "Clinical documentation improvement goes hand in glove with utilization and making sure that everyone follows the regulations and documentation rules," she says.

CMS is starting to align the incentives for the health system to invest in post-acute care management, Ziskind says. Value-based purchasing and significant payment penalties from the readmission reduction program give hospitals a financial interest in investing in initiatives to make sure patients do well in their post-discharge setting, he says.

"The bundled payment initiative puts the healthcare organization at risk from the time patients enter the system through an episode of care. Since the payment model spans more than inpatient care, there is a growing need

EXECUTIVE SUMMARY

For the first time, the Department of Health and Human Services has set specific goals for basing Medicare fee-for-service payments on quality or value by the end of 2018.

- Commercial payers are expected to follow suit and develop their own programs for basing payment on quality or value.
- Since much of the data used in the Centers for Medicare & Medicaid Services quality-based programs is risk-adjusted, complete and detailed documentation that represents all of the patients' conditions and services received is vital.
- The emphasis on care throughout the continuum means that case managers are going to have to communicate regularly with their counterparts in post-acute providers and make sure patients do well in the post-discharge setting.

for coordination between the inpatient and outpatient providers," he says.

In the future, care management models will have to be much more patient-centered than facility-centered and will have to extend beyond the four walls of the hospital and across the post-acute continuum, he adds.

Hospital case managers will need to communicate with their counterparts in patient-centered medical homes and other post-acute settings and share best practices across those sites of care, he says.

Coordination between venues of care and standardization of care is already happening within many hospital systems, but it needs to spread throughout the healthcare system, Ziskind says.

"We know that reducing variation in care reduces both complications and costs. Standardizing processes makes it clear so that everybody knows what to expect every step of the way," he says. Some health systems still have a different model of case management at every facility within the system. "These organizations need to develop a standardized process which will improve care coordination and communication as patients move between sites of care," he says.

Make sure the entire clinical staff, including nurses, understand the Medicare regulations and the consequences of not following them, suggests **Sherry Daugherty**, RN, nurse analyst for Pershing, Yoakley & Associates in Atlanta, who recently joined the firm after 15 years as an emergency department nurse.

"In all my years working in hospitals, nobody ever told me why some of the things we had to do were important. Every time there was a new requirement added, it just seemed burdensome because we didn't know why we were doing it," she says.

Educate the staff on whatever admission guidelines your hospital uses, Daugherty advises. "In the emergency department, we use clinical judgment to determine if someone should be admitted. There was never any feeling that we had to make sure the patient met medical admission criteria," she adds.

Daugherty suggests educating the staff on the ramifications of an audit, how much staff time it takes, and how much it costs to appeal denials. "None of the nurses or physicians I worked with had any idea of the cost of the audit and what going through one entails," she says. ■

Tools improve communication with SNFs, reduce readmissions

Team developed risk assessment tool, discharge checklist

By developing a tool that can be used to identify high-risk patients and a checklist to use when patients transition, UPMC Presbyterian Shadyside Hospital in Pittsburgh has improved communication between the hospital and skilled nursing facilities and reduced readmissions.

"Like everyone in the healthcare industry, we were challenged with readmissions. Our department decided to focus on readmissions from skilled nursing facilities because we felt that case managers and social workers had more control over those than over readmissions in general," says **Ann Kostial**, RN, BS, MHA, senior director of collaborative care management for the 1,282-bed acute care tertiary care hospital.

A team from case management interviewed patients who were readmitted, audited charts, and analyzed readmissions to identify trends in readmissions and the issues that caused them. A case manager who worked on the project researched readmission prevention tools and tools to predict patients at risk, says **Bonnie Schuster**, RN, MSN, director of collaborative care management at UPMC Presbyterian Shadyside.

The team took the information she gathered and worked with a medical director to develop a tool that could predict which patients were most likely to be readmitted. Then the team developed a checklist that includes tasks that should be completed for every discharge to a skilled nursing facility.

The risk tool assesses comorbidities and psychiatric issues; hospitalizations and emergency department visits in the past year; polypharmacy issues and problem medications; poor health literacy and lack of caregiver support, and the plan of care for things such as complex wounds or complex treatments.

The discharge checklist enumerates the tasks that should be done for every skilled nursing discharge. "When we analyzed our readmissions, we found breakdowns on our part. In some cases, when patients had specific clinical issues, the staff was going

at light speed and sometimes failed to enter all the information in the discharge software," Kostial says.

The checklist reminds the case manager to make sure the documentation in the record being transmitted to the facility is complete and accurate and that the staff at the facility are aware that the patient is at risk for readmission.

It lists specific items to be documented, including a description of wounds, information on the patient's mental status, and needs for oxygen.

The checklist also helps the case managers determine if a skilled nursing facility is the right level of care or if a long-term acute care hospital (LTACH) might be more appropriate, Schuster says.

The first section asks the case manager to evaluate if a skilled nursing facility is the correct level of care, if the facility selected can carry out the treatment plan, if there is a nurse practitioner or physician assistant on site, and if the facility has medication available on site.

It reminds the case manager to request an on-site evaluation of the facility and to evaluate the need for a palliative care consult if the patient has had three admissions in the past year. It also reminds the case manager to discuss the risk of readmission and the plan of care with the patient and family and educate them on how the services at a skilled nursing facility are different from those provided by the hospital.

Case managers complete the prediction tool to determine if the patient is at risk for readmission. If the tool predicts that the patient has a high probability of being readmitted, the case manager or social worker who is facilitating the discharge uses the pre-transfer checklist to make sure everything is in place for a smooth transition to the skilled nursing facility.

After the patient is transferred, the case manager calls the nursing home to make sure they received all the information they need to care for the patient and that the transfer went smoothly.

If patients are readmitted to the hospital, the case manager calls the nursing home to find out what caused the readmission. "A large percentage of readmissions are because of a patient's or family member's request. Sometimes they don't like the place they chose. Some nursing homes try to address whatever the issue is and to appease the family but, regardless of their efforts, sometimes patients and families just want to go to another facility. We try to work with the patient and family if they prefer another facility," Kostial says.

When patients come back because they don't like the facility to which they were transferred, the case manager and social worker in the emergency department try to find another nursing home spot for them if they don't meet inpatient criteria. "We tread a fine line here. If we leave them in the emergency department until we find a bed, it affects patient flow. If we aren't successful in placing patients from the emergency department, the patient is bedded in the applicable status and the inpatient care manager or social worker continues to work closely with the patient and family on a safe discharge plan," Kostial says.

If there are clinical issues, the case manager refers the case to the clinical care team for review. "We investigate the issue and find out what we can do to prevent another readmission. Sometimes we determine that the patient isn't at the right level of care and a long-term acute care hospital might have been a better choice," Schuster says.

The new process was piloted on two units with high volumes of nursing facility referrals and readmissions from nursing homes. The tools in the pilot were on paper. The team is working with the hospital's information technology department to develop a tool for the electronic medical record that combines elements of the case management department's tool and a tool developed by the quality department.

"The quality department has a tool that uses historical information as well as admissions information to score the patient electronically. Their tool is clinically driven and uses lab values and patient history. Ours includes psychosocial issues such as caregiver support, and psychiatric issues. We are working in collaboration with them to see if we can combine the two tools," she says. ■

EXECUTIVE SUMMARY

A case management team at UPMC Presbyterian Shadyside Hospital in Pittsburgh has developed an initiative to improve communication between the hospital and skilled nursing facilities in an effort to reduce readmissions.

- The team interviewed readmitted patients, analyzed trends in readmissions and what caused them, and researched readmission prevention tools.
- They developed a risk tool that assesses a variety of issues and use it to help identify patients who are at risk for readmission. The tool covers comorbidities, psychiatric issues, polypharmacy issues, emergency department visits and hospitalization, and other issues.
- They created a discharge checklist that lists the tasks that should be done for every skilled nursing discharge.

Hospital cuts length of stay for babies in the NICU by four days

Team focuses on getting infants ready for discharge

The average length of stay for premature infants in Cedars-Sinai Medical Center's 45-bed Neonatal Intensive Care Unit (NICU) has dropped from 21 days in 2011 to 17 days, following a series of initiatives to improve care coordination and throughput, along with changes in treatment protocols. The unit is part of the Maxine Dunitz Children's Health Center.

Medical advances in the treatment of premature infants are part of the reason for the decrease, but a major factor in the shorter length of stays is the entire multidisciplinary team's focus on coordinating each baby's complex healthcare needs and moving them along the treatment protocol as soon as they are ready, says **Ellen Mack**, RNC, MN, neonatal nurse specialist.

Initiatives include daily rounds by the treatment team, weekly rounds by a multidisciplinary early discharge team, training the bedside nurses to assess the infants for feeding readiness several times a day, and engaging parents in infant care early in the stay.

The unit has an average census in the low 30s. About 30% of babies are covered by MediCal, California's Medicaid provider, Mack says. About 10% of the remainder of babies in the NICU were conceived with reproductive technology, she adds.

The hospital is participating in a subgroup of the California Perinatal Quality Care Collaborative.

"We have been working on shortening the length of stay for many years. Participating in the Collaborative gave us an opportunity to share information with other hospitals and to learn what has been successful for them," Mack says.

The NICU team includes a pediatric case manager, a dedicated RN discharge coordinator who is an experienced neonatal nurse, and lactation consultants who are skilled with working with premature babies.

One of the changes the Cedars-Sinai team has made is to use physiological criteria, rather than weight and length of gestation, to decide if the babies are ready to move to the next step in the treatment protocol, Mack says. "We move patients along based on how they are doing, rather than using set criteria," she says.

Another change is to assess the premies for oral feeding readiness at 32 weeks, two weeks sooner than their old protocol. "Not every baby will be ready to feed, but many are able to take at least one feeding a day," she says.

The bedside nurses have been trained to assess the babies several times a day for feeding readiness, to determine their condition and whether they are ready to move along in the clinical protocol. In the past, an occupational therapist or physical therapist assessed the babies once a day or less frequently.

"Having the nurses assess the infants gives us a more accurate picture of how the babies are doing. A baby might be sleepy when the therapist assesses him but awake later in the day," she says. In addition, the treatment team conducts rounds every day on every patient.

Once a week, a multidisciplinary early discharge team assesses every patient at the bedside for milestones that signal they are closer to going home. The team includes Mack, the case manager, a social worker, a dietitian, the discharge coordinator, representatives from physical therapy and occupational therapy, a lactation consultant, and the physician champion.

Mack reviews the charts the night

EXECUTIVE SUMMARY

An initiative in which the entire treatment team focuses on moving premature babies through the continuum has resulted in a drop of four days in the average length of stay at Cedars-Sinai Medical Center's Neonatal Intensive Care Unit.

- The treatment team has daily rounds on every patient and a multidisciplinary early discharge team assesses every patient at the bedside to determine who is ready to go home and what is holding up the discharge, and to take action to move things along.
- The bedside nurses assess the babies several times a day for feeding readiness and to determine if they are ready to move along in the clinical protocol.
- The team gets parents involved in daily care and gives them hands-on experience so they won't be nervous about caring for the child at home.

before the meeting and identifies areas the team needs to discuss. "I look at what is going on with the patients, are they still in the incubator, how they are eating, and where we are in parent education. We know that when we provide care in an organized fashion, we get where we want to be much quicker and safer," she says.

The team looks at whether the patient is meeting discharge criteria and, if so, what is holding up the discharge. "The rounds help us identify areas where we need to intervene and remove any obstacles to discharge," she says. For instance, the baby is approaching the weight needed for surgery but it hasn't been scheduled. In that case, the physician champion discusses the situation with the surgeon. If the parents need help communicating with the durable medical equipment supplier, the case manager gets involved.

In some cases, the parents are delaying the discharge but instead of saying they are nervous about taking care of the baby at home, they offer other excuses, such as that they have to paint the baby's room, Mack says.

"The social worker or case manager helps the parents think about the situation differently and tells them that the baby needs to be at home. Hospitals are not the best place for anyone, and the safest and best place for babies is to be at home with their family as long as they are physically ready," she says.

The team gets parents involved in daily care whenever possible and engages them in rounds so they'll be aware of what's going on with their infants and the potential for discharge. The team is working on a process that will allow parents to attend rounds by video conferencing when they can't be present. They plan to try the process on a trial basis.

"These babies have never been home before, and their parents have never taken care of them. They are eager to have them home but often are nervous. We start the education process early in the stay and do more than just encourage them to be at the bedside. We involve them in actually providing care for the babies," she says.

The discharge coordinator and case manager work together to coordinate the care of the infants. The case manager works with parents to prepare them for discharge, sets up medical equipment and other services needed after discharge, and coordinates with insurance companies. The discharge coordinator follows the clinical progress of the babies, sets up post-discharge physician appointments, and educates parents on complex issues.

"There is some overlap between the case managers and the discharge coordinator, but both of them work together to make sure that parents are prepared to care for their babies, not just from a practical standpoint but also emotionally," Mack says.

The team tracks readmissions within 30 days and any unscheduled medical interventions the baby needs within 72 hours after discharge. "We look for patterns that give us clues as to what we can do better to avoid the problems," she says. ■

Health system, churches work together to support patients after discharge

Team approach leverages the influence of clergy

A partnership between Methodist LeBonheur Healthcare and 512 Memphis, TN, churches, supports enrolled church members as they transition from the hospital to the community and has resulted in less utilization, lower healthcare costs, lower mortality, and fewer readmissions for participants in the program compared to a similar group.

The Congregational Health Network works this way: When participants are hospitalized, a navigator employed by the hospital and a volunteer liaison based in the church the patient attends work together to see that the patient's needs after discharge are met.

"This program extends the reach of the hospital into the community. When there are more people on the team and involved in care, there is more of a chance that the patient's needs will be covered," says **Teresa Cutts**, PhD, former director of research at the Center of Excellence in Faith and Health at Methodist LeBonheur Healthcare.

The Congregational Health Network was developed in 2006 as a way to address the poor health status of residents of low-income communities in Memphis by leveraging the influence of the pastors and church leaders in the community, Cutts says.

"Memphis is one of the poorest metropolitan areas in the country. Our hospitals serve a population

made up largely of low-income African-Americans who often have difficulty navigating the healthcare system and have social needs that often lead to readmissions. Many of the residents of the area have negative views of the healthcare system and hospital care. A large percentage of our patients are active members of their church and rely on the church community for support," she adds.

The health system assembled a committee of 12 community pastors, hospital representatives, and other community leaders who worked together to develop the program. They created a partnership and a covenant that gives details of what the hospitals will do and what the clergy will do, Cutts says.

Health system leaders and pastors on the committee meet with leaders of other churches in the community to inform them about the program. In turn, the pastors tell their congregations about the program, encourage members to enroll, and recruit volunteers to be liaisons between hospitalized church members and the hospital staff.

More than 20,000 church members have enrolled in the program and have been entered into the health system's electronic medical record.

The more than 600 volunteer liaisons have undergone an extensive education and training program developed by the health system. The classes include mental health, first aid, sickle cell disease, medicine and miracles, screening and prevention of cancer, domestic violence, how to get into the local safety net, social service agencies and what services they provide, and end-of-life issues.

Two local community colleges have participated in the program and have given participants up to six hours of college credits if they complete the program.

The health system has hired 10 full-time navigators dedicated to the program. About half of them are retired healthcare workers. They go through training similar to that of the liaisons.

"We teach them about the Health Insurance Portability and Accountability Act [HIPAA] and the limits of competence. They know when they don't feel comfortable with a situation to call in a clinician for help," Cutts says.

When patients who are enrolled in the program are admitted to the hospital, the health system's electronic medical record flags the patient and the navigator is alerted. The navigators visit patients in the hospital and make sure they want their pastor and church liaison to be involved.

The navigators spend time with the patients and find out the patients' immediate needs, their support system at home and what they are likely to need after discharge, and alerts the pastors and church liaison. "The navigator works as a team with the hospital case manager to determine the discharge needs and begins the conversation with the liaison and the pastor," she says.

The liaison visits the patient in the hospital and works with the church's resources such as visitation teams, fellowship groups, and other volunteer programs to find volunteers to care for pets, run errands, assist with housework and lawn maintenance, grocery shop, prepare meals, pick up medication, and provide transportation for follow-up physician visits.

The liaisons may find someone in the congregation to sit with the patient in the hospital or to stay at home with the patient until a home health provider arrives so the patient won't have to open a door to a stranger.

The liaison and navigator work together to line up community-based social services.

"The model is based on community caregiving. This is not just something the hospital is driving. The community is in charge," Cutts says.

The liaisons also educate church members on healthy lifestyles and disease prevention by speaking to church groups or calling in experts to speak.

The navigators are assigned by geographic areas and have flexible hours. All have offices in the hospital but may be called to one of the churches to help recruit members for the program or to present an educational program.

Before the program began, the healthcare system leadership team educated the hospital staff about the role of the navigator. It took time to sort over the roles and make sure that the navigators were not going to replicate the efforts of the case managers and social workers.

"When the staff began to understand that the navigators and the community liaisons were there to extend their reach into the community after patients are discharged, they began to value their assistance. This program creates a much bigger safety net over a bottomless pit of need," Cutts says. ■

COMING IN FUTURE MONTHS

- Inpatient vs observation: Which is right?
- The case manager's role in the revenue cycle.
- Recruiting and mentoring new staff.
- Why ED case management is so important.

HOSPITAL
CASE MANAGEMENT

CNE INSTRUCTIONS

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CNE QUESTIONS

1. According to Deborah Hale, CCS, CCDS, president of Administrative Consultant Services, the Centers for Medicare & Medicaid Services (CMS) clarified that it is not looking for a separate form for physician certification of an admission and that certification is achieved by a signed inpatient order with the reason for the admission, the plan of care, and an individualized estimated length of stay and the discharge plan included in the medical record.
A. True
B. False

2. In January, the U.S. Department of Health and Human Services announced a goal of tying Medicare fee-for-service to quality or value. What is the target date for tying 85% of payments to quality or value?
A. The end of 2016
B. The end of 2018
C. October 1, 2016
D. October 1, 2017

3. The new rules announced by the Centers for Medicare & Medicaid Services for the Recovery Auditor program change the amount of time the auditors will have to complete complex reviews and notify providers of their findings. What is the new deadline?
A. 60 days
B. 45 days
C. 30 days
D. 3 months

4. The Neonatal Intensive Care Unit (NICU) team at Cedars-Sinai Medical Center revised its protocol for assessing premature infants for readiness to feed. At what age does it assess them now?
A. 38 weeks
B. 32 weeks
C. 30 weeks
D. 29 weeks

CNE OBJECTIVES

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

1. identify the particular clinical, administrative or regulatory issues related to the profession of case management
2. describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the healthcare industry at large
3. discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.