HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Star Ratings show hospitals need to improve the discharge process

Patients report what was good or bad about their stay

For the first time, prospective patients can find out what other patients think of your hospital by checking the Hospital Star Ratings on the Center for Medicare & Medicaid Services' (CMS') Hospital Compare website.

The Star Ratings, which show patients' perceptions of the hospital experience, are based on hospital scores from 22 questions on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which hospitals must send randomly to newly discharged patients. Hospital Compare includes each individual hospital's ratings on 11 composite scores on HCAHPS measures and the new HCAHPS Summary Star Ratings, which are a combination of all ratings.

EXECUTIVE SUMMARY

For the first time, the Centers for Medicare & Medicaid Services is posting Star Ratings, showing patients' perception of care, on the Hospital Compare website.

- Ratings are based on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and include individual scores on 12 composite measures based on the HCAHPS responses as well as state and national averages.
- A big gap between patients who reported receiving discharge instructions (86%) and those who said they understood what to do at home (52%) indicates that hospitals need to revise their discharge teaching and make sure patients understand their treatment plan.
- Case managers need to take the time to fully assess all patients — not just those going to post-acute facilities — to find out their living situations, their support systems, and their need for resources after they go home.

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The website includes state and national averages for each metric.

The metrics posted on Hospital Compare show huge gaps between the percentage of patients who said they were given information about what to do during their recovery at home (86%) and those who said they understood their care when they left the hospital (52%), says **Jackie Birmingham**, RN, BSN, MS, CMAC, vice president emerita of clinical leadership for Curaspan Health Care Group, a Newton, MA, healthcare transition management software firm.

Patients are not likely to base their choice of hospitals solely on the Star Ratings, says **Linda Sallee**, RN, MS, CMAC, ACM, IQCI, director for Huron Healthcare, headquartered in Chicago.

In fact, CMS advises patients to consider many factors in hospital choice, including word-of-mouth information.

People tend to go to hospitals in their community or where their doctor practices, Sallee points out. "But people are becoming more savvy and are paying attention to quality data, so the Star Ratings could have some effect. It would be a good idea for hospitals to pay attention to their scores and take steps to improve," she adds.

One major reason for improving patient satisfaction is the announcement from CMS in the Inpatient Prospective Payment System proposed rule for fiscal 2016 that it intends to add metrics from three HCAHPS care coordination questions to the Value-Based Purchasing program in fiscal 2018.

The questions focus on patients' understanding of their care when they left the hospital and ask if the staff took their preferences into consideration in deciding their post-acute care needs; if patients had a good understanding of how to manage their health when they were discharged; and if patients clearly understood the purpose of taking their medications.

"This is just another indication that CMS is serious about improving the discharge process and patient care," Sallee says.

Birmingham advises hospital case managers to review their hospital's scores, particularly on the discharge planning and care transition measures, to determine where there is room for improvement.

"When just over half of patients understand their care when they leave the hospital, it indicates that the discharge process needs to be improved. We already knew this, but now it's been proven that just handing patients a sheaf of papers doesn't translate into them understanding what to do. It's time for hospitals to revise the way they assess patients who are appropriate for home health services or home without services to develop a discharge plan," she says.

HCAHPS surveys aren't sent to people with skilled nursing facility referrals. The ratings come from patients who were discharged from home, Birmingham points out.

"This indicates that case managers need to spend as much time with patients who are going home as they do with those who are going to a skilled nursing facility. Case managers should assess patients' needs and develop a discharge plan based on their functional needs and strengths to determine their discharge destination. When it's home, spend more time with the patient, spend more time with the staff nurses and therapists, if appropriate, to make sure patients understand their role in the

discharge plan," she says.

Case managers haven't always created a discharge plan for patients being discharged to home, but that needs to change, Sallee says. "Case managers need to give patients going home all those safety nets that will help keep them from coming back to the hospital when the care they need could be provided somewhere else," she says.

Discharge planning has gotten short shrift in many hospitals because of the time-consuming nature of the process and because many case management departments don't have enough staff to spend a lot of time with patients, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in Dallas-based Case Management Concepts.

"With CMS' focus on reducing readmissions and improving quality, it's important to make sure patients understand what they need to do after discharge. If case managers rush in at the last minute to develop a discharge plan, it impacts patients' perception of the care they are getting as well as having the potential for developing a discharge plan that won't work," Cesta adds. *(For more on how to help patients understand their discharge plan, see related article on page 84.)*

Case managers should assess every patient and take the time to find out their support systems and other situations at home that could impact a safe transition, she says.

Case managers need to broaden their focus and find out what issues patients face when they get home and what resources are available to fill that need, Sallee says. Take the time to dig deeper and find out the situation at home as well as the patient's needs, she says.

For instance, you may see an elderly patient who is in the hospital for a short stay, but who will need someone to be with him or her 24 hours a day after discharge. "The patient may say that he lives with his daughter, but it may be that everyone in the family works or goes to school and the patient would be alone for a good part of the day. If case managers don't take the time to find out that detail and have the family make arrangements for a daytime caregiver, the discharge may not be successful," Sallee says.

"An unsuccessful discharge may cause the patient or the family member who helps the patient complete the HCAHPS give the hospital a low score, which will affect the Star rating," Birmingham says.

Case managers should develop a good relationship with patients and their families, talk with them in easy-to-understand language about the discharge plan, and get their approval of the plan, Cesta says, adding that Medicare Conditions of Participation mandate involving patients and families in the discharge plan.

Cesta suggests that case managers visit their patients every day during the hospital stay and reinforce and reiterate the discharge plan. "Patients can't hear everything in one session. You've got to teach them multiple times," she says. When you go into patients' rooms, sit down and take the time to get to know the patients, she adds.

"When case managers fly in at the end of the hospital stay and have no relationship with the patient, they shouldn't wonder why their scores are low," she says.

Case managers have to take the time to sit down and talk to patients and involve them in the discharge plan, says **Eric Heil**, co-founder and chief executive officer at RightCare, a healthcare information technology company based in Horsham, PA.

He recommends that case managers and nurses talk about the potential discharge plan during conversations with the patient throughout the hospital stay.

"Case managers should talk to patients, find out their preferences and their needs at home, and use the information to create a discharge plan and talk to them about their discharge plan throughout the hospital stay," he says.

"Integrating conversations about the next level of care into the clinical workflow is critically important. If nurses or case managers wait until the day of discharge to talk about the discharge plan, the patients are likely to feel unprepared," Heil adds.

Good communication starts with the hospital staff. "If the team members communicate effectively among themselves, they are likely to communicate well with the patients," he says.

Case managers can do a lot in conjunction with nursing to improve their hospital's scores on the discharge information questions, says **Wanda Pell**, MHA, BSN, director, Novia Strategies, a national healthcare consulting firm.

"If patients don't know they are being discharged until the morning of the discharge, they don't feel ready," Pell says. But if the staff sets the expectation for the length of stay in the beginning, the patient and family won't feel rushed and they are more likely to feel prepared to go home, she adds. *(For a look at one facility's discharge collaborative initiative, see related article on page 86.)* ■

Work with nursing to make sure patients understand the discharge plan

Take time to establish relationships early in the stay

Case managers may not be in charge of all their patients' discharge education, but it is their responsibility to make sure that patients receive the education they need to care for themselves at home and that they understand it, or that referrals are made after discharge to continue their education, says **Linda Sallee**, RN, MS, CMAC, ACM, IQCI, director for Huron Healthcare with headquarters in Chicago.

"Case managers need to make sure patients have a follow-up phone call and the name and number of someone to contact if they have questions, can't get their medication, or have symptoms," Sallee says.

The entire staff has to engage the patient in preparing for discharge, says **Jackie Birmingham**, RN, BSN, MS, CMAC, vice president emerita of clinical leadership for Curaspan Health Group, a Newton, MA-based healthcare transition management software firm. Case managers should make the rest of the healthcare team aware of the impact it has on patients when you just hand them discharge instructions as they prepare to go home, she adds.

"Thanks to the Star Ratings, we now have evidence that almost half of patients don't understand. The hospital staff often doesn't understand the business end of the hospital. They may not know about HCAHPS, their hospital's scores, and what they mean. Case managers must be educators on the nursing unit about the HCAHPS and patient education," Birmingham says.

Discharge teaching isn't effective if it's done right at discharge, says **Eric Heil**, co-founder and chief executive officer at RightCare, a healthcare information technology company based in Horsham, PA.

Instead of trying to teach patients what they need to do to care for themselves at home at the end of the stay when they are eager to go home or anxious about going home, start the conversation early in the stay, or before the stay if it's an elective procedure, he recommends.

> "IT'S NO LONGER ABOUT JUST GETTING A PATIENT OUT OF THE HOSPITAL AND BACK HOME OR TO A SKILLED NURSING FACILITY."

This means that case managers need to identify patients who will need extensive instructions at admission, alert the nursing staff, and to work with the patients throughout the stay to prepare them for discharge, he adds.

Heil suggests breaking the discharge teaching down into short segments and giving patients written instructions to study while they are in the hospital so they will have time to ask questions.

Make sure you're talking about whoever is going to care for the patient once he or she gets home, Sallee says. Make sure the written discharge information has a place for patients to write questions so they'll be prepared when they get a follow-up phone call or see their physician. Include information on who to contact if they have questions about their care or if services such as home health or durable medical equipment don't show up, Sallee adds.

Develop a relationship with patients early in the hospital stay and repeatedly reinforce the discharge information, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in Dallas-based Case Management Concepts.

Go into patients' rooms, sit down, and look like you have time to talk, she suggests. Discuss the importance of taking their medication as instructed and make sure they have a way to get prescriptions filled and can afford to pay for the medication, she says.

When patients report on the HCAHPS that they weren't told about their discharge medications, it comes back to healthcare professionals' inability to communicate with patients, Cesta says.

Educate your patients on the importance of scheduling a follow-up visit with their doctor after discharge and make sure they have a timely appointment and a way to get there, Cesta says.

When patients are going to have home health services, prepare them about what to expect, says **Wanda Pell**, MHA, BSN, director of Novia

Strategies, a national healthcare consulting firm.

"Some patients think 'home health services' means somebody is going to be in the home taking care of them 24/7. They are disappointed and unhappy when they find out differently. Properly setting the patient's and family's expectations is paramount," she adds.

Heil has worked with hospitals that allow the home health nurse who will be seeing the patient after discharge visit in the hospital. "This way, the patient won't be opening the door to a stranger. Establishing a relationship before discharge can make a huge difference," he adds.

Call patients after discharge to check on how they're doing and to make sure they have filled their prescriptions and have an appointment with a physician, Cesta says.

Patients' healthcare literacy plays a significant role in their responses to the HCAHPS questions, says **John Zelem**, MD, FACS, vice president, compliance and physician education at Executive Health Resources, a Newtown Square, PA, consulting firm.

"If there is a language barrier or they don't understand their discharge instructions because they are too technical, it can be reflected in their answers to the HCAHPS," Zelem says.

Give your discharge instructions in simple English or, in the case of patients who aren't fluent in English, in the language they prefer. Give them materials that are concise and easy to read to supplement what you are telling them. Use the teach-back method to make sure they understand.

Case managers need to stop thinking about a "discharge plan" and start thinking about a "transition plan," Sallee says.

"It's no longer about just getting a patient out of the hospital and back home or to a skilled nursing facility. It's about helping the patient transition to the next level of care with all the resources needed," she says. ■

Star Ratings don't give the whole picture of the hospital

Ratings are subjective and based on past years, experts say

When the Centers for Medicare & Medicaid Services posted its Star Ratings on the Hospital Compare website for the first time, only 5% of hospitals received the highest five-star rating.

The majority of the 3,553 hospitals rated received two or three stars (56%), with 34% getting four stars and 3% getting just one star.[1]

The ratings, published in April, were based on responses of patients discharged between July 1, 2013, and June 30, 2014. CMS plans to update the HCAHPS Star Ratings quarterly.[1]

The Star Ratings give consumers a quick visual about a hospital's rating. However, the Star system is based totally on patient evaluations and doesn't include other indicators of quality. The questions are subjective and measure only the patient's perception of care, points out **Wanda Pell**, MHA, BSN, director, Novia Strategies, a national healthcare consulting firm.

She predicts that informed consumers will not rely totally on the Star Ratings when they choose a hospital.

Like Value-based Purchasing, the readmission reduction program, and the hospital-acquired condition reduction program, the Star Ratings are based on data from a couple of years ago, says **John Zelem**, MD, FACS, vice president, compliance and physician education at Executive Health Resources, a Newtown Square, PA, consulting firm.

If hospitals are doing better now than they were a year ago, it won't show up for at least a couple of years, he adds.

HCAHPS can be implemented in four survey modes: mail, telephone, mail with telephone follow-up, or active interactive voice recognition, each of which requires multiple attempts to contact patients, Zelem says. Hospitals must survey patients throughout each month of the year. Hospitals paid under the Inpatient Prospective Payment System (IPPS) must achieve at least 300 completed surveys over four quarters. HCAHPS is not restricted to Medicare patients, he adds.

"Everything is relevant. If patients have just one bad thing happen during their hospital stay, they may give negative answers to all the questions," he says.

The Star Rating system is just one tool among many that patients can use when making healthcare decisions, says **Akin Demehin**, senior associate director of policy for the American Hospital Association.

"While Star Ratings could be an effective way to make quality information easier to understand, the devil is in the details. There is a risk of oversimplifying the complexity of quality of care or misinterpreting what is important to a particular patient, especially since patients seek care for many different reasons," he adds.

REFERENCE

1. HCAHPS Summary Star Rating. www.hcahpsonline.org. Centers for Medicare & Medicaid Services, Baltimore, MD. Accessed May 20, 2015. ■

Setting the time and date helps enhance patients' discharge experience

Initiative aims at improving patient satisfaction

As the result of a hospital-wide initiative to improve the discharge process, more than 70% of patients at the University of Wisconsin Hospital and Clinics have a designated discharge date and time, and on average, patients leave within 28 minutes of the set time.

"When we analyzed our patient satisfaction data, we saw that patient satisfaction with the speed of the discharge process after they were told they could go home hovered around 49%. This level of satisfaction was not nearly what we wanted it to be. Our clear aim was to improve patient satisfaction with discharge by scheduling a set date and time and having patients leave within 30 minutes of that time," says **Ann Malec**, MS, RN, NEA-BC, director of medical nursing for the 592-bed medical center.

A multidisciplinary team that included the medical center's Patient and Family Advisors (PFAs) developed two goals to enhance patients' discharge experience, Malec says. "First we wanted to keep patients updated with their anticipated discharge date, with the understanding that it's a moving target. Once the patient was deemed medically ready for discharge, we also wanted to set a specific time for the discharge, ideally the day before the discharge," Malec says.

The discharge collaborative team included physicians, nurses, case managers, pharmacists, physical therapists, Patient and Family Advisors (PFAs), and representatives from quality, business planning and development. Eventually, the larger group was pared down to approximately 10 people who serve as steering committee members.

It took a year of planning to develop the discharge initiative, Malec says.

"We got feedback from people throughout the hospital. We met with the senior leadership, the quality council, and the executive committee. We went to department meetings and high-level nursing meetings. Our goal was to raise awareness about the discharge collaborative and why improving the discharge process was important. If there was a meeting, we were there," she says.

The steering committee made rounds on the nursing units and talked to the nurses on the unit about what worked well in the discharge process and where the problems were, Malec says. They also met with patients and family members to find out how to make the discharge experience better.

The medical center's PFAs were key members of the discharge collaborative team, Malec says. PFAs are lay individuals who have been patients or family members of the patient. They serve on hospital advisory councils and committees and help the staff see processes and practices through the eyes of the patient. *(For details on how the PFAs work with the hospital staff, see related article on page 91.)*

Patients and family members consistently reported that they would

EXECUTIVE SUMMARY

More than 70% of patients at the University of Wisconsin Hospitals and Clinics are assigned a designated discharge date and time, and the average patient leaves within 28 minutes of the set time.

- A multidisciplinary discharge collaborative including Patient and Family Advisors (PFAs) developed the initiative after getting feedback from people throughout the hospital, as well as from patients and family members.
- The anticipated date of discharge is documented in the medical record and written on the communication board in the patient's room.
- Ideally, the time is added the day before the discharge.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

The Top 10 Mistakes You May Be Making In Your Case Management Department!: Part 2

Toni Cesta, Ph.D., RN, FAAN

Introduction

Last month, we began our discussion of the top 10 mistakes you may be making in your case management department. After 30 years of experience in testing and retesting hospital case management models, it is safe to say that we have identified some basic elements that make for a contemporary and state-of-the-art case management department. In this month's *Case Management Insider*, we will continue our discussion of the top 10 mistakes by reviewing mistake numbers 3-5.

Last month, we talked about the first two mistakes made by case management departments:

1. Role confusion or, "Who is doing what?"
2. Inadequate staffing ratios

AFTER 30 YEARS OF EXPERIENCE... IT IS SAFE TO SAY THAT WE HAVE IDENTIFIED SOME BASIC ELEMENTS THAT MAKE FOR A CONTEMPORARY AND STATE-OF-THE-ART CASE MANAGEMENT DEPARTMENT.

Case Management Department Mistake Number Three: "Not Using the Best Practice Case Management Model Design"

Each of these mistakes feed directly into our third mistake, which has to do with the model design of the department. The model used for your department is critically important and relates directly to the roles and functions of the case managers and social workers as well as the staff-to-patient ratios for each discipline. So mistake number three is to not use one of the best practice model designs that have been tested and found to work well.

What is a model of care? A model is a description used to help visualize something that cannot be directly observed. Because care delivery models such as case management models cannot be seen, we use descriptors to provide a picture of the model in terms of its structure and processes. The field currently supports two contemporary models. Each is designed to address the challenges hospitals are facing today in terms of value-based purchasing, penalties for readmisisons and high mortality rates, the efficiency measure, and other issues asociated with the Affordable Care Act such as integration across the continuum of care.

The Integrated Case Management Model

In the integrated model, all roles are performed by a single RN case manager. This model integrates previously disconnected roles and functions. Included in the integrated model are all the roles we discussed in Part 1. For the registered nurse case manager these include patient flow, utilization management, resource management, transitional and discharge planning (with a clinical focus), and avoidable delay tracking. For the social worker they include psychosocial counseling and interventions, and discharge planning with a psychosocial focus.

The nurse case manager integrates the roles of patient flow, utilization management and discharge planning into one role that applies to all patients asigned to her. The nurse case manager is repsonsible

for referring any psychosocially complex patients to the social worker as they are identified.

The integrated model requires that all patients are seen by a nurse case manager. For some patients that are considered "high risk," they may also be followed by a social worker.

Collaborative Case Management Model

In this model, a third team member is added. The third member is called the Utilization/DRG Manager, or "business associate," and is responsible for the "business" aspects of case management such as conducting clinical reviews for the purpose of transferring information to a third-party payer. They are also responsible for clinical documentation improvement. As such, the staffing ratios are different in the collaborative model. The case manager is responsible for assessing, planning, and coordinating care and outcomes management.

Staffing Ratios in Collaborative Model

- Case Manager: 15 – 23
- Business Associate: 20 – 40
- Social Worker: 1:17 active cases

These staffing ratios can be directly compared to the ratios we looked at last month that were for the integrated model. As you can see, the ratios for models in which utilization management is a separate function are different. The RN case manager can carry a larger caseload, but with the addition of the business associate, the cost can be higher overall as a third member is added to the team. The role of the social worker is the same in both models.

Each model brings pros and cons. The key differences between the two models are the integration of utilization management into the role of the case manager versus the separation of the role through the addition of a third team member.

How are These Models Alike?

Both the integrated and collaborative models build on the interrelationships of the nursing and social work disciplines to achieve the expected case management outcomes. They both require strong social work support and will not work if they are inadequately staffed. Caseloads and workloads must be balanced.

Case Management Department Mistake Number Four: "Lack of Clerical Support"

When implementing a case management model, there are some tools and support structures that should be in place to provide a foundation for the professional staff, the nurse case managers, and social workers. Mistake number four is not having clerical support staff to free up the case managers and social workers from performing functions that non-licensed personnel could/should perform.

Clerical support staff is an integral part of the case management department. They are a component that is often lacking and considered unaffordable or "not in the budget." In reality, the lack of clerical support staff produces a lot of "time-wasters" for the case managers and social workers. They can actually optimize the staff ratios we have previously discussed by allowing the professional staff to engage in functions that only they can perform. By investing in clerical level staff, the entire department becomes more efficient and therefore more effective.

Titles and Roles

There are a variety of titles that can be given to your support staff. Some examples include extenders, case management assistants, clerks, expeditors, etc. These positions are gaining popularity as the role of the case manager has become more complex every year. Similar positions in nursing would be the nursing assistant who assists the staff nurse so she can work "to the top of her license." So many case managers and social workers spend half their day faxing, ordering transportation and durable medical equipment, or on the phone trying to reach a facility or vendor. These tasks can be assigned to an extender. You can break out the work by categories and assign the tasks as per your own department's needs and comfort level.

Extenders are utilized the most optimally if they are assigned to specific case managers and social workers. In this way a relationship can be formed between them. There should typically be one extender for every seven to eight professional staff. The extender should be assigned to the same professional staff every day.

Extender Roles in Discharge Planning

Below are some of the items that can be assigned to the extender to support the role of discharge planning:

- Make packets for transfer to skilled nursing facilities (SNF), nursing homes (NH), rehabilitation facilities, or long-term care hospitals (LTAC),

• arrange ambulance transport,
• arrange taxi or care service transport,
• take prescriptions to outpatient pharmacy and fill them for patients being discharged (depending on the location of the pharmacy),
• arrange for durable medical equipment, and
• make referrals to outside agencies.

In addition, the extender can support the professional staff and the department in ensuring that the department is compliant with regulatory requirements.

Examples of these tasks include:
• Deliver the second Important Message to Medicare beneficiaries,
• deliver Medicare observation letters,
• provide choice lists for SNFs and home health agencies to the patient/family, and
• collect choice list when patient/family have completed the choice process.

Extenders can also help with care coordination by:
• Updating huddle notes as needed, and
• making initial patient follow-up phone calls.

Extenders should also document where appropriate and necessary. Some examples of appropriate documentation include:
• Documenting the receipt of the Important Message by the patient,
• documenting that the choice list was provided and discussed with the patient/family, and
• documenting that authorization was obtained from a third-party payer and making note of the authorization number.

Responsibilities under the category of utilization management include:
• Obtaining authorization from commercial insurance companies, and
• notifying the case manager of requests for clinical reviews.

The extender has to be educated and trained in how to perform these functions and tasks. He or she also needs to be educated in how best to communicate with the case management team. Conversely, the case managers and social workers need to feel comfortable delegating to the extenders. This comfort level comes over time and as the extenders become more proficient in their roles. It is therefore critical that the extenders understand how best to communicate. They should be seen as an integral part of the case manager and social worker team.

DESPITE THE HEALTHCARE INDUSTRY'S PUSH TOWARD INTEGRATION OF INTERDISCIPLINARY CARE TEAMS, MANY ORGANIZATIONS STILL REMAIN SILOED.

Tips for Extender Communication

• Ask the case manager or social worker when they need to have a task completed, with specific timeframes such as immediately, within an hour, by the end of the day, etc.
• Update the case manager or social worker on the status of the request if the timeframe cannot be met.
• Update the patient/family on the status of a referral that has been made.
• Keep the lines of communication open at all times with the patient and family in terms of the discharge planning process.
• Communicate the outcomes of any conversations with any team members to the case manager and social worker.

By properly training the extenders and remaining in constant communication with them, they can greatly improve the outcomes of any case management department and pay for themselves many times over.

Case Management Department Mistake Number Five: "Working in Silos"

Despite the healthcare industry's push toward integration of interdisciplinary care teams, many organizations still remain siloed. This means that they are functioning in isolation of each other, with minimum communication or integration of planning, implementation of the care plan, or management of patient care outcomes and variations from expected outcomes.

Mistake number five is the lack of integration of case management, both vertically and horizontally. Because of case management's history of coming from utilization review, many case management departments have been slow to integrate themselves as part of the interdisciplinary care team and work apart from, and without integration with, the other members of the team. When this occurs, communication tends to happen only when necessary and in a "reactive" mode, rather than a "proactive" one.

So, who should case management integrate with? Our integration must also happen both within and beyond the hospital walls and should include the following at a minimum:

- Social workers and RN case managers within the same department;
- physicians;
- nurse leaders;
- staff nurses;
- ancillary services such as radiology, laboratory and pharmacy;
- non-acute care providers;
- senior executives.

Early case management models did not allow for such integration and caused fragmentation of the departments, which resulted in higher cost, poorer integration of care processes, and longer lengths of stay. By the early 1990s, some hospitals began to combine some functions of case management and became "partially" integrated. Unfortunately, social work and RN case managers often remained separated, sometimes in completely different departments. Because the work of the case manager and social worker is so intertwined, this also resulted in less optimal outcomes for the case management department and the hospital.

As we have discussed, today we know that the most effective departments are those that provide for full integration, both vertically and horizontally.

Managing Horizontally

As case managers, you must integrate the work you perform horizontally in the organization. This means that your communication must align with those you work with who are lateral to you. These are your colleagues — they do not report to you, and you do not report to them.

Horizontal communication and integration becomes particularly important as you manage your patient's care progression. Tests, treatments, and procedures need to be organized in such a way that care does not become delayed or done out of order. Each day that the patient is in the acute care setting must be optimized. This optimization requires careful planning and prospective thinking. When a test, treatment, or procedure needs to be facilitated, it is always best to have a professional relationship with the person in the department with whom you are communicating. So, for example, if you need to facilitate an MRI, having a contact person in that department will make it much easier for you to achieve your desired outcome when necessary. A strategy for making this happen is to have a contact in that department with whom you can communicate regarding delays in care. The case management department should have such contacts in each department with which they interface.

> HORIZONTAL COMMUNICATION AND INTEGRATION BECOMES PARTICULARLY IMPORTANT AS YOU MANAGE YOUR PATIENT'S CARE PROGRESSION.

Managing Vertically

In addition to communicating horizontally, you must also communicate and manage those to whom you report, and those who may report to you. This is the process of managing vertically. As case managers, it is our responsibility to keep the manager or director of our department informed of any issues that may require their intervention or knowledge. You should also escalate to your director when you have reached an impasse with a particular issue, physician, or other department. Until you escalate that problem, you continue to "own" it. Sometimes you must communicate an issue to your direct supervisor in order to keep him or her aware of a situation, even though there may be nothing he or she can immediately do about it.

You must also communicate with your physician advisor. The physician advisor's role is to intervene when you have an issue with a physician or third-party payer that requires a physician-to-physician discussion. As with your director, you should communicate with the physician advisor when you can no longer solve a physician-related problem on your own.

You may also have case management extenders reporting to you. As we have discussed, keep them informed as to the work that needs to get done and hold them accountable for meeting timelines that you have given them.

Next month we will continue to discuss the top mistakes made by hospitals in the design of their acute care case management departments. We will discuss the need to perform your work within specific timeframes, including operating the case management department seven days a week! ■

like to know the discharge date in advance so they could prepare and have a chance to ask questions before the last day, says **Peggy Zimdars**, a volunteer Patient Family Advisor who served on the steering committee.

"Patients and family members told me that it would be helpful to get information about their discharge goal early in the stay. When the nurse or doctor says, 'good news, you can go home today,' it's not always such good news for the patient and family because there is a lot to do to get ready at home. Knowing the date earlier ensures a safe and smooth transition home. Patients told me they didn't mind that the date might be changed, but they did like knowing in advance," she says.

The committee originally set a goal of identifying a tentative discharge date for patients within 24 hours of admission, Malec says. "However, after receiving additional feedback from physicians who were concerned about the ability to accurately project the anticipated date for patients with complex medical issues, the goal was updated to assign an anticipated date within 48 hours. Even with the updated goal, clinical judgment remains the priority over an arbitrary date that has no clinical relevance," she adds.

The discharge collaborative team remains committed to assigning an anticipated discharge date as soon as possible and on keeping the patient and family informed of any updates, she says.

The anticipated date is documented in the medical record and on the communication board in the patient's room. As soon as the staff can confirm a firm discharge date, they add it to the communication board and the medical record. Then, ideally the day before discharge, the staff adds a specific time for the discharge, Malec says.

"We are able to meet our goal of documenting a confirmed discharge date and time more than 76% of the time. On average, patients leave within 28 minutes of the set time. Our next challenge is to move the discharge time from late afternoon to earlier in the day, ideally before noon," Malec says.

The discharge collaborative initiative has helped with coordination of care for patients transferring to nursing homes by identifying a set time for discharge, Malec says. "With a set date and time identified, the case managers and nursing staff are able to coordinate the transfer in a more streamlined fashion," she says. The staff is able to transfer patients during the day when more resources are available at the accepting facility. Knowing the anticipated time for the discharge also helps the family plan, Malec says.

Having a discharge date and time helps the staff to plan and to get their part of the discharge process completed in a timely manner, but things don't necessarily go smoothly all the time, Malec says. For instance, if a patient is scheduled for discharge the next day at 10:30 but the lab results indicate a problem, the discharge will be delayed until the patient's condition gets better. "Patient safety is always a priority," Malec says.

"It's tricky. We can't completely firm up the time until the lab tests come back. The pharmacy can't do medication reconciliation until the discharge orders are signed and the nurse can't do the final teaching until the medication reconciliation is complete. It's a work in progress but as it evolves we hope to see improvement," she says.

Satisfaction scores rose slightly after the initiative was implemented, Malec says.

"While promising, this peak was not statistically significant. Hopefully, with time, we will continue to see sustained improvement in patient satisfaction scores. Anecdotal comments from patients and families have been positive and provide reinforcement that we are moving in the right direction," she says. ■

Patient and Family Advisors help keep staff focused on the patients

They are key partners in hospital initiatives

When the University of Wisconsin Hospital and Clinics embarked on its discharge collaborative project to improve patient satisfaction with the discharge process, the organization's Patient and Family Advisors (PFAs) were an important part of the process.

"Our Patient and Family Advisors are key partners in all we do. They remind us that our goal is to always remember the voice of the patient and to help us when we get off track," says **Sandra Salvo**, UW Health program manager for patient and family-centered care.

The purpose of involving the Patient and Family Advisors in improvement projects is to help the staff provide patient- and family-centered care and to get the patient perspective on hospital processes and systems, Salvo adds.

PFAs participated in the initiative from the beginning and were invited to be at the discharge collaborative weekly meetings and to speak up about their discharge experiences. **Peggy Zimdars**, a longtime PFA and co-chair of the UW Health Patient Family Advisory Council, served on the steering committee for the process improvement initiative.

Often, the staff and the patients see things in a different way, Zimdars points out.

"The hospital seems like organized chaos to patients. What's going on is routine for the staff but not for the patients. Patients are very stressed when they're in the hospital, but the staff expects the patient to be flexible," Zimdars says.

UW Health began seeking input from Patient and Family Advisors in 2006, Salvo says. Initially, there was one PFA council for the adult hospital and one for the children's hospital.

"Now we have PFAs serving across the organization on 12 Patient and Family Advisory Councils, dozens of committees and quality councils, improvement teams, facility design teams, and executive search committees, as well as assisting with patient education materials and telling patient stories to educate, inspire, and inform our staff and providers," she says.

Zimdars says she reminds staff members to keep focused on individual patients and families, rather than getting caught up in metrics. "I tell the staff that the data they are discussing has a name, a family, and a life outside the hospital and that the hospital staff should always incorporate the patient in everything they do," she says.

For instance, the PFAs who worked on the discharge collaborative reminded the team that it is important to have a set time for discharge.

"Having a PFA at the discharge collaborative meetings was helpful. It helped the staff put a face on the people they are working with and it made them realize that this really is about the patients and families and not just the staff," says **Ann Malec**, MS, RN, NEA-BC, director of medical nursing for University of Wisconsin Hospital and Clinics.

Patient and Family Advisors may self-nominate or be nominated by the staff or other PFAs, Salvo says. They go through a screening and orientation process before they begin their duties. They are assigned to a variety of roles throughout the health system.

"The voices of our PFAs have been heard at any point where we interact with patients and their families, including clinical protocols, how we do rounding and handoffs, infection control, palliative care, provider communication and empathy, patient education, and discharge planning, to name a few. They have helped us keep our focus on our patients' and families' needs while also recognizing the driving forces within healthcare in which we need to operate," Salvo says. ■

IPPS proposed rule is more of the same with emphasis on quality

What's missing is a decision on the two-midnight rule

The Inpatient Prospective Payment System (IPPS) proposed rule for fiscal 2016 continues the Centers for Medicare & Medicaid Services' commitment to shift the Medicare program to reimbursing providers based on the quality, rather than the quantity, of care they give to patients.

"The proposed rule is a mixture of more of the same and an expanded push toward quality. It is well over 1,000 pages and covers a lot of ground," says **Kurt Hopfensperger**, MD, JD, senior medical director of audit, compliance, and education at Executive Health Resources, a Newtown Square, PA, healthcare consulting firm. "It reaffirms that ICD-10 will start Oct. 1, expands inpatient quality reporting, modifies the Value-Based Purchasing and readmission reductions programs, and asks for comments on expanding the bundled payments initiative."

What it doesn't do is address the two-midnight rule or set a payment system for short inpatient stays, he adds. Instead, CMS stated that it is considering feedback it has received, including the recommendation from the Medicare Payment Advisory Commission (MedPAC) that it do away with the rule entirely.

CMS says that it expects to include a further discussion of "the broader set of issues related to short inpatient hospital stays, long outpatient stays with observation

services" in the Outpatient Prospective Payment System final rule for 2016, which is issued at the end of October and goes into effect Jan. 1, 2016. Hospitals are still being audited for compliance with the two-midnight rule through the Probe and Educate program administered by the Medicare Administrative Contractors (MACs).

There is a precedent for CMS to clarify the Inpatient Prospective Payment System rules in the OPPS, Hopfensperger points out. Last fall, CMS made changes to the inpatient certification requirements for physicians in the OPPS, he adds.

None of the changes announced in the proposed rule are a surprise, says **James Ketterhagen**, MD, principal, and safety and quality practice lead for Novia Strategies, a national healthcare consulting firm.

"CMS is continuing its emphasis on quality through Value-Based Purchasing, the hospital-acquired condition reduction program, and the readmission reduction program," he says.

In the proposed rule, CMS is continuing to raise the bar for hospitals, says **Theresa Brandon**, CPA, SPHR, managing director and revenue cycle practice lead for Novia Strategies.

"In this rule, they have taken away some measures and added new ones. The fact that they are continuing to reassess significant measures gives us clarity about how seriously they take them and how payments will continue to be tied to performance," Brandon says.

CMS has started with a low percentage of reimbursement tied to quality and is ratcheting up, Ketterhagen points out. "They are tweaking the programs by dropping one metric and going on to the next one. Accountable care organizations are becoming more common. The bundled payment initiative is going to expand, and at some point, there will be no such thing as fee-for-service."

"When you look at the direction Medicare is moving, there's no question that in five or 10 years or so, the payment method for healthcare providers will not look anything it does today. We've seen only the first foray into the idea of pay-per-performance," Ketterhagen continues.

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services' (CMS') 2016 proposed rule for the Inpatient Prospective Payment System (IPPS) continues to shift the Medicare program to reimbursing providers based on quality metrics.

- CMS continues to raise the bar for hospitals by adding new metrics to Value-Based Purchasing, the Hospital Readmission Reduction program, and the Hospital-Acquired Condition Reduction program.
- Case managers should continue to educate physicians on the effect that the quality metrics have on the hospital bottom line and work with the multidisciplinary team to ensure that patients get the care they need in a timely manner and that documentation reflects the patient's condition and services received.
- In the proposed rule, CMS announced that it is considering feedback it has received on the two-midnight rule and will include a further discussion of the issue in the Outpatient Prospective Payment System final rule.

Rule highlights

Highlights of the proposed rule include the following:

- CMS proposes to add eight new measures to the Hospital Inpatient Quality Reporting program in fiscal 2018 and to remove nine measures.
- The agency also states its intention to add a care coordination measure to Value-Based Purchasing in fiscal 2018. The measure, which has been in the Hospital Inpatient Quality Reporting program, is a combination of metrics from three questions on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) that focus on patients' understanding of their care when they left the hospital.
- The proposed rule includes a proposal to increase the weight of the Patient Safety domain in Value-Based Purchasing from 20% to 25% in fiscal 2018 and to add a 30-day mortality rate for chronic obstructive pulmonary disease in fiscal 2021. The payment reduction for the Value-Based Purchasing program is slated to rise from 1.5% to 1.75% in fiscal 2016.
- For fiscal 2017, CMS is proposing to expand the population of patients with pneumonia in the readmission reduction program to include patients with a principal discharge diagnosis of aspiratory pneumonia and sepsis, or respiratory diagnoses with a secondary diagnosis of pneumonia. Currently, only patients with a principal discharge diagnosis of

viral or bacterial pneumonia are part of the population, Brandon says.

• The Hospital-Acquired Condition penalty remains at 1%, but the weight of the domains has changed. In 2015, 35% of a hospital's score is based on the Patient Safety Indicator 90, a composite of eight measures. The remaining 65% is based on two healthcare-associated infection measures: central line-associated bloodstream infections and catheter-associated urinary tract infections. In fiscal 2016, CMS proposes to reduce the Patient Safety Indicator 90 domain's weight to 25% and to 15% in 2017. "CMS is focusing more on infections than general patient safety indicators," Ketterhagen says.

• The proposed rule adds surgical site infection for colon surgery and abdominal hysterectomy to the Hospital-Acquired Condition prevention program in fiscal 2016, and methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* colitis (*C. diff*) in fiscal 2017.

• CMS is seeking comments on the potential future expansion of the Bundled Payments for Care Improvement initiative it launched in 2011. The pilot project pays a fixed price for a wide range of health services by multiple providers over a specified period of time or episode of care. *(For details on bundled payments, see* Hospital Case Management*, October 2014, Vol. 22, No. 10, page 135.)*

The emphasis on quality and improving care for patients makes the role of the case manager more important than ever before, Hopfensperger says.

"As long as we have inpatients and outpatients, as long as we have documentation issues, performance measures, and quality reporting, we will always need case managers. What we're seeing is that utilization review and utilization management are more important than they were five to seven years ago and the trend is going to continue," he says.

Many physicians may not have a thorough understanding of the CMS quality improvement programs and their impact on the hospital, but CMS is already planning similar programs for physician practices, Ketterhagen says. "Hospital case managers are in a position to educate physicians about the performance metrics and the significant impact on the hospital's bottom line while reminding physicians that similar programs will affect their practices in the future," he says.

The changes in the healthcare environment are leading to the breakdown of silos that have existed for many years within hospital operations, Brandon says.

"Regulations, rules, and reporting requirements have become so complicated that it takes a collaborative effort of case managers, social workers, nurses, physicians, and finance professionals to determine how to deliver the right amount of care and get reimbursed for as much of that as is permissible," Brandon adds. ■

Get ready for ICD-10: It's really going into effect

Documentation must be more specific

After a series of fits and starts, it appears that ICD-10 will take effect on Oct. 1.

All claims submitted to any entity covered by the Health Insurance Portability and Accountability Act (HIPAA) on or after Oct. 1, 2015, for inpatient discharges or outpatient services provided in all healthcare settings, must use the ICD-10 codes for medical diagnoses and inpatient procedures.

Otherwise, the claims may be rejected and providers will have to resubmit them using the ICD-10 codes, says **Susan Wallace**, MEd, RHIA, CCS, CDIP, CCDS, director of inpatient compliance for Administrative Consultant Services, a Shawnee, OK, healthcare consulting firm.

This means that there will be some patients who will be admitted in September but whose discharge needs to be reported under ICD-10, Wallace says.

The few non-HIPPA entities not required to use ICD-10 include workers' compensation and medical liability in homeowner or automobile policies. But many of those agencies have also said they will be ready to accept the new ICD-10 codes, Wallace says.

The World Health Organization's International Classification of Diseases, 10th revision (ICD-10) has been used by other countries for 22 years, reports **John Zelem**, MD, FACS, vice president of compliance and physician education at Executive Health Resources, a Newtown Square, PA, consulting firm. The United States will be the first country to use the coding system

for reimbursement purposes. The other countries have been using it to identify and follow trends, he says.

Implementation of ICD-10 originally was scheduled for Oct. 1, 2013, and was postponed for a year to Oct. 1, 2014, to give providers more time to prepare. Then, after a push by the healthcare industry, Congress postponed implementation until Oct. 1 of this year as part of a bill dealing with the sustainable growth rate system for reimbursing physicians.

"The healthcare arena was waiting to see if Congress was going to delay ICD-10 again. Then we waited to see what Centers for Medicare & Medicaid Services [CMS] said in the Inpatient Prospective Payment System [IPPS] proposed rule. Now we know that it's really going into effect," Wallace says.

While ICD-9 uses five-digit numeric codes, ICD-10 is a seven-digit alpha-numeric coding system, she says. The expanded fields make it possible to track much more detailed information about the patient's condition.

ICD-10 has 70,000 diagnosis and procedure codes, compared to 17,000 codes in ICD-9. Because the coding for ICD-10 reflects a greater level of detail, coders will need more accurate and detailed information to assign the correct code, she says.

If they haven't started already, case managers need to educate physicians on the specificity of documentation that will be required for ICD-10 and work with them to document completely, Wallace says.

Physician education about ICD-10 and the level of documentation required is essential, Zelem says. "If physicians don't get it right, the coders can't produce it," he adds.

"Typically, many physicians do not adequately document the acuity with which patients present. I've done a number of chart reviews and this is what I see: Physicians tend to document for other physicians and not for coders, utilization management, clinical documentation improvement, or auditors. That's why physician education about documenting for the right audience is so important," Zelem says.

On and after Oct. 1, if the documentation is not complete, the coder may not be able to assign a code and, depending on the hospital's protocol, may send the case back for more specific documentation, delaying reimbursement, Wallace points out.

To make sure they are prepared for the implementation of ICD-10, some hospitals are dual coding for both ICD-9 and ICD-10, Zelem says. "Case managers and clinical documentation improvement specialists are working with physicians to improve their document to meet the new requirements for specificity. This can be significant help in ensuring that the hospitals are ready," he says.

An example of one big change in ICD-10 is laterality. Now, there are codes for left, right, both, and neither. In the past, providers could document that a patient had a broken finger. Now, the document must specify which finger and whether it's on the left or right hand, Zelem says.

"Laterality is simple and easy. But there is a long list of changes that aren't so easy," Wallace says. For instance, ICD-9 has one code for atrial fibrillation. There are four codes in ICD-10, she adds.

Surgical cases may be a source of incomplete documentation for many hospitals, Wallace says. "Surgeons are not accustomed to documenting operative reports with the specificity required by ICD-10," she says. "There have been a lot of instances when there was not enough information in a surgical report to even assign a code," she adds.

The documentation also needs to give details on the acuity of the disease. For instance, is the patient's asthma intermittent, or mild, moderate, or severely persistent?

"Urosepsis is still being documented by some physicians, but that documentation does not exist in ICD-10," Wallace says. "Therefore, those cases will have to be returned to the physician," she adds.

If the coding is wrong because of lack of documentation, the hospital may not be paid appropriately, Wallace says.

"The list of things for case managers to work on has gotten longer. Hospitals need to have a system for concurrent documentation review so the case managers can make sure the documentation is complete and detailed so it doesn't hold up the claims," Wallace says.

To access the proposed rule, visit the IPPS Proposed Rule Home Page at http://go.cms.gov/1c7aU0L. ■

COMING IN FUTURE MONTHS

- What's up with the two-midnight rule?
- Bundled payments may be in your future
- Inpatient vs. observation: It's still confusing
- Why you need to work with post-acute providers

HOSPITAL
CASE MANAGEMENT

CNE INSTRUCTIONS

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CNE QUESTIONS

1. The metrics from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) posted on Hospital Compare show that 86% of patients surveyed said they were given information about what to do during their recovery at home. What percentage said they understood their care when they left the hospital?

A. 86%
B. 52%
C. 75%
D. 30%

2. At the University of Wisconsin Hospital and Clinics, the goal is to set an anticipated discharge date for patients within what amount of time after admission?

A. 24 hours
B. 36 hours
C. 48 hours
D. 72 hours

3. In the Inpatient Prospective Payment System (IPPS) proposed rule, CMS states that the payment reduction for the Value-Based Purchasing program will increase in 2016. What percentage of Medicare payments will be withheld?

A. 1%
B. 1.5%
C. 1.75%
D. 2%

4. When ICD-10 goes into effect Oct. 1, all claims for discharges on or after that date must be submitted using ICD-10 codes. This means that claims for patients who were admitted in September but discharged in October need to be submitted under ICD-10.

A. True
B. False