HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

## INSIDE



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# Going 'Beyond the Hospital Walls' May Be Further than You Thought

*Community organizations hold a key to value-based care*

Remember when "coordinate care beyond hospital walls" meant collaborating with skilled nursing facilities and home health agencies? Not anymore.

With new initiatives such as bundled payments and Medicare spending per beneficiary, CMS and other payers put hospitals at risk for as long as 90 days after the patient is discharged from the hospital. This means case managers are going to have to expand their care coordinating efforts to organizations in the community that can help meet patients' medical and psychosocial needs long after they leave the hospital.

"Traditionally, case managers were responsible for patients from curb to curb. Now, as the focus shifts to transitions of care and hospitals become at risk for what happens to patients after discharge, case managers need to look at the bigger picture of the entire community when they plan the post-

## EXECUTIVE SUMMARY

With new initiatives that put hospitals at risk for what happens to patients for as long as 90 days after discharge, case managers need to look at resources in the community when creating a discharge plan.

- Assess your patients' medical and psychosocial needs after they leave the hospital and make sure they are connected with community services that can help them stay safe and healthy.
- Gather a comprehensive list of community organizations that can provide assistance and support for patients after discharge and create alliances with them.
- Assess your patient population and identify any gaps in transitions, then work to fill them, even if your hospital isn't yet at risk for patients after discharge.



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acute short-term and long-term arrangements for patients," says **Cheryl Warren**, MS, RN, CMAC, chief clinical integration officer for Hallmark Health, a network of community hospitals and health centers in the Boston area.

CMS launched its first bundled payment initiative, the voluntary Bundled Payments for Care Improvement, in 2013, and has been steadily adding episodes of care. The mandatory Comprehensive Care for Joint Replacement bundled payment initiative began April 1 in 67 markets, and the Oncology Care Model bundled payment program with 200 physician groups and 17 payers launched July 1. CMS has proposed a mandatory bundled payments pilot project for acute myocardial infarction and coronary bypass surgery to begin July 1, 2017, and announced plans to add hip and knee fractures to the mandatory orthopedic bundled payment program.

The Medicare spending-per-beneficiary initiative, the Value-Based Purchasing Program, and the readmission reduction program all base reimbursement at least partially on what happens after discharge. In addition, CMS' proposed discharge planning conditions of participation includes requirements that case managers take available community resources into consideration when creating a discharge plan.

"The writing is on the wall: Payment reform is not going to go away, and hospital case managers need think about whether their patients are going to need help with another transition after the initial post-acute services are complete," says **Cheri Bankston**, RN, MSN, director of clinical advisory services for Curaspan, a subsidiary of naviHealth.

To survive in the changing healthcare market, hospitals are going to have to look at new ways of doing things, adds **Angie Roberson**, MSN, RN, ACM, director of case management at Spartanburg (SC) Regional Health System.

"As we try to shift from volume to value in the healthcare industry, the key is to go beyond collaborating with the post-acute providers and to be involved in the community. It means more than collaborating with what we think of as healthcare providers — it means developing relationships with Meals on Wheels, United Way organizations, and local charitable organizations," Roberson says. *(For more details on Spartanburg Regional Health System's community partnerships, see related article on page 143.)*

Hospitals are becoming increasingly at risk for the cost of patient care after discharge, points out **Donna Zazworsky**, RN, MS, CCM, FAAN, principal of Zazworsky Consulting in Tucson, AZ. This means that case managers need to develop relationships with community resources that can help meet patients' needs in the community after discharge, she adds.

"Without question, in today's healthcare environment it is critical for hospitals to work with community agencies and to ensure that there is some kind of care coordination for patients who need it after they are discharged," Zazworsky says.

Even if patients are being discharged to home, case managers need to have transition care in place to create a seamless handoff from the hospital to the patient's primary care provider, or, in some cases, a federally qualified health center, Zazworsky adds.

Bankston strongly recommends that case management directors begin immediately to educate their staff

about changes in reimbursement and how to coordinate care transitions more efficiently. "Many case managers are unclear about payment reform and how bundled payments and other new initiatives can impact the hospital. Case management directors need to make sure their staff understands the impact of these changes and should consider redesigning the discharge process to create more efficient workflows to transition patients to the right care at the right time," she says.

"Most patients experience multiple transitions — from hospital to post-acute care facility, and from post-acute care facility to home — and support is needed at each step of the recovery," Bankston says.

For instance, when patients receive home health services, they may need assistance from organizations like housing assistance or Meals on Wheels after they are discharged from home health.

Another transition challenge is the gap between discharge and when the home health provider arrives, Zazworsky adds. Many times, the home health agency can't send anyone to the home until several days after the patient is discharged, she says. The first few days after discharge are the most critical, and if there is a gap, patients may end up back in the hospital, she adds.

"We used to focus on shortening the length of stay in the hospital and other inpatient hospital-focused metrics, but now with bundled payments and other initiatives that pay for the entire episode of care, we need to look at length of stay and other quality metrics in post-acute facilities and consider additional alternatives for patients being discharged," Warren says.

She advises case managers to consider the community programs that are available to keep patients at home and healthy. For instance, some patients may be able to go home if they get help with grocery shopping and housekeeping she adds.

"There is pressure to move patients out of acute care, but skilled nursing facilities and home health agencies aren't always the best discharge setting for every patient. Case managers are strengthening their relationship with community resources that can help patients return home and stay there safely," Bankston says.

> "THERE'S NOT A ROAD MAP THAT TELLS YOU WHAT YOU SHOULD DO TO ACHIEVE EXCELLENT OUTCOMES. EVERY COMMUNITY HAS TO DEVELOP ITS OWN INDIVIDUAL STRATEGY."

The reality is that it takes more time for case managers to arrange community services than it does to arrange a transfer to another facility, Bankston points out. However, linking patients with community agencies and providers can increase patient satisfaction and improve outcomes at a lower cost, Bankston says.

"It can be disconcerting for patients, especially the elderly, to go to a completely new environment. If they can be at home in a familiar setting or surrounded by family and friends, they have better outcomes. Case managers can make that happen by linking them to community organizations that can meet their needs," she says.

"There's not a road map that tells you what you should do to achieve excellent outcomes. Every community has to develop its own individual strategy," Roberson adds.

Roberson points out that while there are numerous care transition models, there's no model that fits the needs of every patient.

"When you talk about care transitions into the community, one size doesn't fit all. Hospitals have to come up with multiple strategies and interventions in order to meet the needs of everyone. Case managers have to figure out how to provide the correct intervention for each individual patient to get the outcomes we need. Then we have to come up with a way to fund it and be fiscally responsible with the limited dollars we have," Roberson says.

The traditional relationship between hospitals and post-acute providers has to change, Warren points out. "In the past, hospitals and post-acute providers had an informal relationship built around marketing and referrals. Hospitals referred patients, and the post-acute providers screened them and accepted them or not," she says.

Now, hospital case managers need to be working with the hospital's data analyst to determine where patients are going, lengths of stay for each provider, readmission rates, and other quality metrics, she adds.

"Case managers have to work more closely with everyone — not only post-acute facilities, but families and physicians as well. With bundled payments, hospitals need to follow the patients for up to 90 days post-acute and monitor the quality of care they're receiving along with their resource utilization," she says. ■

# Start Now to Identify Gaps in Transitions Before the Hospital is at Risk

*Work with community organizations on creative solutions*

Even if your hospital has little or no financial risk for what happens to patients after treatment in an acute care setting, case managers should connect with community organizations that provide the types of resources your patients need, says **Cheri Bankston**, RN, MSN, director of clinical advisory services for Curaspan.

"Hospitals should start collaborating with community organizations now so they're prepared for the transition. Case management departments should expand their database of community resources and reach out to the entities in the community to find out what services they provide and how to make referrals," she says.

Start by assessing community resources and the population you are trying to serve and identify any gaps in services, she says.

Bankston suggests organizing a group of stakeholders, including hospital leadership, case managers, and even local payers, to look at the gaps and find ways to fill them.

If you identify gaps in service for a particular population, look for a solution. "This is where hospitals get creative. Some hospitals are partnering with the local emergency medical services, churches, or Area Agencies on Aging," she says.

In order to ensure that patients who don't have a primary care provider have a follow-up appointment and continuing medical care, **Donna Zazworsky**, RN, MS, CCM, FAAN, principal of Zazworsky Consulting in Tucson, recommends working with the major primary care providers in the area, including large physician groups, federally qualified health centers, rural health clinics, and any other

## Turn that Little Black Book into a Comprehensive Database

*Case managers need quick access to community resources*

With payers' increasing emphasis on costs over the entire episode of care, case managers need to expand their address books to add resources throughout the community, says **Cheri Bankston**, RN, MSN, director of clinical advisory services for Curaspan.

"Hospitals have to be proactive and prepare for the future, so when patients are being discharged the staff will have resources at their fingertips," she says.

Bankston advises case management directors to collaborate with staff and share known resources, and continually update the list of agencies and services.

To begin, case managers should contact each agency and find out what services they provide, any limitations, the criteria to receive the services, and any information they need to provide services for your patients, she says.

Consider inviting representatives of the organizations to your hospital to inform the case management staff about the services they provide and how case managers can help their patients to access the services. "Most agencies are more than happy to send someone in to speak to the staff about the type of services they offer," she says.

Once you have all the information, utilize tools to easily identify community organizations that can help with their patients' individual needs, Bankston says.

If at all possible, create or utilize an electronic platform so staff can quickly match community resources with patient needs. "Many software companies offer a way to automate this kind of information," she says.

"Whether it's a hard copy or a computerized version of the list, there has to be an easy way for the staff to search the list to find and match patients with appropriate resources," she says. ■

organizations that provide primary care.

Compile a list and determine the chief contact in those organizations and who from the hospital should meet with them, Zazworsky suggests. "While the case managers are the ones the hospital case managers will be working with, they aren't necessarily the decision-makers in the organization," she points out.

She suggests that the director of case management in the hospital initiate a meeting with the chief executive officer, the chief operating officer, or the medical director of each primary care provider to open the dialogue. "In some cases, it may be more effective for the chief medical director of the hospital and the chief medical director of the primary care practice to meet," she says.

Before the meeting, identify the high-risk patients who are potential readmissions and compile data on the number of patients and their discharge needs.

"Point out that these individuals don't qualify for home health but have a high rate of readmissions, and brainstorm on what kind of program could be set up to provide care," she says.

"It's been my experience that primary care providers are very happy to have a working relationship with hospitals. It's a matter of developing a flow of processes and how referrals would work," she says.

When Zazworsky helped create a partnership between a hospital and a federally qualified health center to provide coordinated care after discharge for appropriate patients, case managers from the health center and the hospital created a flowchart of how the program would work. They included details such as what kind of patients were appropriate and how the case managers at the health center would be notified.

The federally qualified health center placed its own physician at the hospital where he serves as a hospitalist. The physician treats the patients in the hospital and assists with transitions of care, she says.

Volunteers from local churches provide support and education for low-income patients with chronic conditions who are being discharged from the hospital in a model program, Zazworsky says. The program originated in Memphis, but similar programs are cropping up all over the country, she adds. The volunteers go through training that includes information about the disease and tips on how to interact with patients. They visit patients in their homes and make sure they have everything to meet their medical and psychosocial needs. *(For more details on one program, the Congregational Health Network, see the April 2015 issue of* Hospital Case Management.*)* ■

# Community Partnership Provides Home Visits for At-risk Population

*Hospital, EMS collaboration cuts ED visits, readmissions*

A collaboration between Rockdale Medical Center in suburban Atlanta and community partners has reduced readmissions, ED visits, and calls for emergency services among high-risk, medically underserved patients with poorly controlled chronic conditions.

The Healthy@Home Community Paramedic Program, which started in January 2015, sends a specially trained paramedic from National EMS to provide health checks and education to patients at home. The paramedic works closely with a social work case manager at the 138-bed acute care hospital who coordinates community resources for the patients. The program is funded by Health TRUST Rockdale, the grant-making division of the Hospital Authority of Rockdale County (HARC). The trust was created using proceeds from the 2009 sale of Rockdale Medical Center, formerly a public hospital, to private company LifePoint, Inc. The Rockdale Coalition for Children and Families administers the fund.

In the first 18 months of operation, the Community Paramedic Program provided almost 1,000 home visits to more than 100 chronically ill Rockdale County residents, according to **Jennifer Phillips**, MSW, case manager at Rockdale Medical Center, and medical social worker/patient navigator for the Healthy@Home program.

The hospital experienced a 2% housewide drop in readmissions in 2015, Phillips says. Patients in the program have experienced a 25% reduction in avoidable readmissions, a 32% decline in ED visits, and a 45% drop in non-emergent 911 calls.

The Georgia Hospital Association awarded its 2016 Community Leadership Award to the Community Paramedic Program and Rockdale Medical Center, and recognized Phillips as a "Hospital Hero" for her work in the program.

The hospital already had a targeted readmission reduction program when **Benny Atkins,** chief operating officer of National EMS, the county's contracted emergency medical services provider, proposed his organization and the hospital collaborate on a program to provide home visits by paramedics to at-risk patients.

"We felt this was a natural fit with what we were trying to do," Phillips says.

The program targets patients with poorly controlled chronic medical conditions, including those with no insurance, those who are underinsured, and patients without a primary care provider. It includes patients who have been to the ED more than five times in 18 months, those who have been readmitted to the hospital within 30 days of discharge, people with chronic conditions including diabetes, heart failure, pulmonary diseases, or recurrent wounds, elderly individuals, and those identified by a physician as being high risk.

When patients are referred to the program, Phillips meets with them in the hospital whenever possible. Otherwise, she contacts them by telephone. "I always try to meet them face to face to discuss the program and get their permission for the paramedic visits," she says. She completes a detailed clinical and psychosocial assessment that identifies the patients' needs and barriers to following their treatment plan.

Phillips uses the information from the assessment to create a rough plan for the patient and shares it with the paramedic team. She also enters each patient's medical information into an online charting system that uses cloud technology. This way, the hospital and the paramedics can review the chart and have an idea about the patient's condition before going to the house.

The program takes a three-pronged approach to improving the health of the Rockdale County community, Phillips says. "Through the assessment and the home visits, we determine what their needs are. Through the social services network in the area and our partnership with the Rockdale Coalition, we can meet their needs. We can pay for transportation, patient copays, and office visits, as well as helping patients access community services," she says.

Teaching patients to become self-supportive is the third component of the program. "We don't provide lifetime support. Our goal is to get them on their feet, establish them with a primary care provider, and teach them to take responsibility for their own health," she says.

The program helps patients get established with a primary care provider and any specialists they may need to get their problem under control. The program connects patients with food banks, utility assistance, and housing assistance programs, and helps them apply for Medicaid if they are eligible.

**Jeanann Briscoe**, NREMT-P, an experienced paramedic who came out of retirement to staff the program, visits the patients in a specially equipped van dedicated to the program. Other paramedics assist her when necessary.

When Briscoe goes into a patient's home, she assesses the patient's living condition and contacts Phillips if there are social issues that weren't uncovered during the assessment. Depending on the needs, Phillips coordinates the services herself or guides Briscoe on what community resources can provide assistance.

"Our goal is to teach the patients how to access the services themselves," she says.

During each visit, Briscoe takes the patient's vital signs, conducts a health check, and looks for signs of an acute problem. "My goal is to anticipate what care the patients need before they end up in the emergency department or the hospital," she says. She may contact Phillips, who will arrange an immediate visit with a primary care provider or specialist and, if needed, contact the Rockdale

## EXECUTIVE SUMMARY

Rockdale Medical Center in suburban Atlanta teamed up with community partners on an initiative that has reduced readmissions and ED visits by high-risk, medically underserved patients.

- The program's medical social worker/patient navigator contacts referred patients — preferably in person while they are in the hospital — and assesses their medical and social needs and creates patient plans.
- A specially trained paramedic visits patients at home, checks on their health, educates them on their conditions and how to manage them, and assesses their living conditions and needs.
- The social worker and paramedic work together to fill in the gaps in care and connect patients with community agencies that can meet their needs.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

# Is Your Case Management Department Making the Grade?

*By Toni Cesta, PhD, RN, FAAN*

## Introduction

As a case manager or an administrator of a case management program in your organization, you may be called on to participate in the evaluation of the case management model, its effects on the organization, or its effects on patient outcomes. You may have direct responsibility for evaluating the effectiveness of the model, the success of the case manager's role, or the case manager's performance.

Whenever possible, it is important to have an evaluation process and a plan set up before implementation or re-engineering your model or department. This is particularly true for those outcomes that affect the organization. Categories such as length of stay (LOS), third-party payer denial rates, readmission rates, avoidable delays, patient satisfaction, and cost of care should have baseline benchmarks against which the hospital can judge success or failure. Other indices, particularly those related to clinical or patient outcomes, will evolve over time.

YOU MAY HAVE DIRECT RESPONSIBILITY FOR EVALUATING THE EFFECTIVENESS OF THE MODEL, THE SUCCESS OF THE CASE MANAGER'S ROLE, OR THE CASE MANAGER'S PERFORMANCE.

## Outcomes as Indices of Quality

Broadly speaking, outcomes can be grouped by those that have an effect on the organization versus those that have an effect on patients. These indicators may be the best measures of quality because they provide an understanding of the functioning of the organization and its effects on the product of services and patient care. Outcomes are the result of actions or processes. In patient care, they are defined as the goals of the healthcare process. A good outcome is one that has achieved the desired goal.

Case management, through the use of tools such as guidelines, multidisciplinary action plans (MAPs), and clinical pathways, and through case management team conferencing, allows healthcare providers to prospectively identify the expected outcomes or goals of care. There are no organizational or clinical processes or tasks that are carried out that do not have an expected outcome attached. Therefore, outcomes in their narrowest sense allow us to understand the effects on an individual patient, and in their broadest sense provide us with an understanding of the functioning (i.e., efficiency and effectiveness) of an organization or the healthcare system at large. These linkages provide us with an understanding of the structure (the organization), the process (the delivery system), and the expected outcomes (goals of care).

There are different types of expected outcomes of care. Some are related to the organization's performance, but are not directly related to the patient's health. Others are related to the patient's health, but are not directly related to the organization's performance. Still others are solely related to the clinical processes, meaning they are purely clinical in nature.

Case management outcomes can be categorized into the following four groups:

- quality,
- financial,
- productivity, and
- regulatory compliance.

## Quality Outcome Metrics

Some outcomes directly affect the patient's clinical quality or their perception of that care, such as the following:

1. patient satisfaction,
2. turnaround time for tests, treatments, procedures, and consults,
3. readmissions,
4. discharge/disposition delays, and
5. avoidable delays.

## Patient Satisfaction

Understanding patient satisfaction with the care and services we provide helps us to improve those services over time and to continuously improve the patient's level of satisfaction with the care they receive. Patient satisfaction data are either collected toward the end of the hospital stay or soon after discharge. All hospitals, and many other healthcare organizations, collect and monitor data on patient satisfaction. Unfortunately, there may not always be a mechanism for feeding that information back for the improvement of system processes or expected clinical outcomes as they relate to the case management department.

## Turnaround Time for Tests, Treatments, Procedures, Consults

Turnaround time (TAT) can be used as a measure of an organization's process improvement and efficiency after the introduction of case management. Facilitating care and managing the patient through the healthcare system should improve the TAT for completion of tests and procedures. The TAT should be measured from the time the physician places the order until the order is completed and results are recorded in the medical record. Acceptable timeframes should be decided in advance. For example, the completion time for CT scans may be 24 hours from the time the order is written until the results of the CT scan are placed in the medical record.

Monitoring of these periods can be done concurrently or retrospectively through the medical record. Concurrent data collection is always preferred because it is both more accurate and timely. If any problems or delays are identified, they can be addressed immediately. Retrospective data collection, on the other hand, may be more difficult because of lapses in documentation in the patient's medical record, or simply the inability to obtain the necessary information. In addition, when problems are finally identified, it is late to try to resolve them. Delays in service turnaround time should be tracked and trended. High volume delays should be reported to the appropriate department. Examples include turnaround time for completion of tests, treatments, procedures, and consults, as well as the reporting of same.

Finally, relationships should be shown between the reduction in TAT and the LOS. As before, it may be difficult to prove sound relationships between LOS reductions and TAT because many other factors may have an effect on the LOS.

## Readmissions

Readmissions have become a standard metric for case management. Because CMS reports them on a 30-day readmission cycle, most hospitals have begun reporting them that way. However, you may want to consider expanding your reporting to include the following:

- 30-day,
- 15-day,
- 24 hours, and
- same day.

These additional time frames allow for the identification of the root causes of readmissions that happen closer to the day of discharge. This methodology allows you to refine all readmissions into additional subsets to work on the causes and corrective actions.

Another method for reporting readmissions is by payer. Consider reporting in the following ways:

- Medicare,
- Medicaid, and
- Managed care.

Looking at all payers will help reduce your overall readmission rates, as additional payers will most likely be applying penalties in the future. While not all readmissions are avoidable, some are. Understanding and tracking the hospital's performance over time will ensure that everything is being done to reduce those readmissions that are avoidable.

## Discharge/Disposition Delays

Discharge and disposition delays are issues associated with the department's inability to transition the patient out of the hospital in a timely manner. These issues may have to do with the availability of services in the community, family issues, financial problems, or physician issues. They may also be related to the performance of the individual case manager/discharge planner. To evaluate the performance of the case management department in terms of its discharge planning processes, the department should consider monitoring and analyzing these issues on a regular basis.

## Avoidable Delays

An avoidable delay occurs when what is supposed to happen does not take place. You can think of avoidable delays as a deviation from a standard, or omission of an activity or a step from a predetermined plan, norm, rate, goal, or threshold. Generally, variances are expectations that are not met. Avoidable delays are often the result of delays, interruptions, additions, or omissions of patient care activities and processes.

Avoidable delay data collection is important because it provides the basis for improvement in patient care activities, processes, outcomes, and quality. The mechanism of data collection is usually decided by the steering committee charged with implementing the case management model and the use of case management plans. Some institutions have delegated this responsibility to a case management department or a quality improvement committee/council. Regardless of who is responsible, the process should be made consistent across the various care settings that exist in the same institution.

There is no standardization in the method of classifying avoidable delays. They can be classified into different categories depending on the needs of your organization. Traditionally, the most common broad categories used to classify avoidable delays are patient, family, internal system, external system, and provider.

## Financial Outcome Metrics

Many case management outcomes are directly related to the bottom line, or financial performance, of the organization. Examples of these include the following:

- cost per day/stay,
- length of stay, and
- third-party denials of payment.

## Cost Per Day/Stay

Clinical cost accounting methods are being used more and more as a means of understanding not only hospital charges, but also the true costs of care. This information can be used to negotiate realistic and appropriate managed care contracts because the hospital understands exactly what costs are associated with the care of a specific population of patients. Cost accounting can also be used as a way of measuring the financial effect of case management on the organization.

Although understanding that reduction in LOS of a particular patient population is clearly important, it is also important to determine the amount of resources consumed in the management of that population. This issue has become critical now with the introduction of the Efficiency Measure, or "Spending per Medicare Beneficiary." Organizations often focus on reducing the LOS but neglect to include an effort to improve the practice patterns related to tests, procedures, and treatments (pharmaceuticals and others), and eliminating the unnecessary activities. Sometimes they even distribute the same number of tests and procedures across the days left after reducing the LOS. This keeps the cost of care the same even though the LOS is reduced. Reducing the LOS but consuming the same amount of resources is not as valuable and should be avoided. This will not have the same long-term benefits of shortening the LOS but also reducing the amount of resources used in the care of that case type of patient.

The two main goals of clinical cost accounting are to identify the organization's standard use of materials for a particular diagnosis-related group (DRG), and define the standard cost of each clinical service. An understanding of these costs allows the organization to assess its costs relative to the normal reimbursements, such as Medicare, Medicaid, and other payers. This information also provides a frame of reference or benchmark against which the organization can compare itself with competitors.

Internally, clinical cost accounting helps the hospital measure its internal treatment patterns. This information can be linked to the medical staff to determine which physicians are rendering the most cost-effective care. Allowing physicians to compare their cost per case with the expected cost or that of their colleagues may provide them with information they can use to improve their practice and in the revision of case management plans.

## Length of Stay

Length of stay is a broad umbrella term that can be interpreted in ways to indicate the amount of time allotted to the care, treatment, or recuperation of a patient. In the inpatient setting (e.g., acute, subacute, or skilled nursing facilities/nursing homes) it can be measured by the number of bed days or the number of days the patient remains in the hospital. In the home care setting, it is calculated by the number of visits to the home and the number of hours or minutes per visit or the total number of hours. The LOS in the ED may be measured in hours or parts of an hour (15 minutes). LOS statistics are most commonly used in the hospital setting. They are often

used as an indicator of the success of case management in conjunction with or in the absence of a cost accounting system.

To determine success or failure of case management and its effect on LOS, hospitals must have a clear understanding of what their LOS goals are and compare those with the current LOS statistics in the organization. Comparisons can be made between the hospital and a variety of benchmarks. The first should be the Medicare and non-Medicare DRG average LOS. Although DRGs are not the primary reimbursement system in every state, they are still used for analytical purposes. It is important to understand the history of the organization so that realistic LOS reduction goals can be set. The hospital should also benchmark against comparable hospitals. These hospitals may or may not be close geographically. National databases can be used for this purpose, such as the University Health System Consortium.

## Third-Party Payer Denials

Third-party payer denials are a commonly used financial metric. Denials can be related to actual dollars lost and are easily measured and tracked. The department of case management should keep track of initial denials received as well as those lost or recovered after appeal. Trending of the data can demonstrate significant financial returns to the hospital. The data should be routinely reconciled against the data being reported by finance to ensure that both departments are reporting in similar fashion.

To monitor denial data, the case management department must record and enter accurate data in a timely fashion. The data should be audited periodically to ensure that it is accurate. The denials can be correlated to actual dollars based on the hospital's specific reimbursement rates.

The following are ways in which denials can be aggregated and monitored:

- measure reductions in initial denials,
- measure reductions in final denials,
- measure percent reductions on each of the above over time,
- determine denial reversal rate,
- measure effect of physician advisor, and
- aggregate by physician/payer.

## Productivity and Regulatory Metrics

Monitoring departmental compliance with regulatory indicators is important as a measure of compliance, but should be kept separately as an indicator and should not be included in your report card.

Regulatory compliance examples include the following:

- providing patients with choice lists for home care and nursing homes,
- appropriate documentation of discharge planning assessments,
- use of Condition Code 44,
- compliance with the Two-Midnight Rule, and
- appropriate documentation of patient discharge disposition.

Productivity measures are indicators of the volume of work performed by the department. Although they may give an indication of the amount and complexity of the work, these numbers alone don't demonstrate the organizational outcomes, but rather the volume of the work itself. If monitored, they should be used for the internal evaluation of the department and of the case management staff and should be used within the department only. The department may find, however, that it needs to evaluate the work performance of individuals in the department to demonstrate the need for more staff members. In these circumstances, productivity measures are appropriate.

Case management leadership may consider using some of the productivity measures to evaluate staff members' performance in conjunction with their annual performance reviews.

Examples of staff productivity measures include the following:

- caseloads,
- number of patients discharged with services by type of service,
- number of case management assessments completed,
- number of case management assessments completed within 24 hours of admission,
- number of insurance reviews completed,
- number of interventions on avoidable day issues, and
- avoidable days capture rate.

## Summary

Measuring your case management department's performance can add value in many ways. It can help to demonstrate case management's unique value in improving the cost and quality of care. It can help to make the case for additional case management resources when necessary. Finally, case management data can be used to identify areas of improvement for the department as well as the organization as a whole. ■

Coalition about any copay that is needed.

She educates the patients about their diseases and their medication, and coaches them on nutrition, exercise, smoking cessation, and other lifestyle changes that can improve their health. "We teach patients the signs and symptoms that indicate they should call their doctor. Our goal is have them calling their primary care provider on their own within the first month," she says.

During the home visits, Briscoe establishes a rapport with patients and discovers needs that aren't immediately apparent. For instance, after several visits, one man admitted he didn't understand the information he'd gotten in the hospital because he couldn't read well. Briscoe went over the information with him and alerted his primary care provider and insurance company to give him verbal instructions.

"Health literacy is another huge barrier. Medical terms are hard for people to understand, so I go through the information and break it down," Briscoe says.

Briscoe visits once a week for the first month, then gradually tapers off the visit until the patients feel confident to care for themselves. Phillips is always available by telephone after people have completed the program.

The hospital has been working with Facie Goodman, resource coordinator of the Rockdale Coalition for Children and Families, to build a network of social resources for county residents, Phillips says. Among the participants are a family-owned pharmacy that works with the uninsured, a durable equipment company that gives the program a discounted rate, a local physician office that takes patients in the program, and the Mercy Heart Free Clinic. ■

# As Healthcare Becomes Value-based, Hospital Partners With the Community for Patient Care

*Two projects aim to fill gaps in care for the uninsured and Medicaid patients*

Just a short time ago, **Angie Roberson**, MSN, RN, ACM, director of case management at Spartanburg (SC) Regional Healthcare System, was a typical healthcare case management director in a traditional role. But now, as healthcare shifts toward a pay-for-performance model, Roberson's role has expanded and crossed over into initiatives in which the hospital partners with providers at other levels of care and in the community.

"Hospitals have to change the way they operate as the Centers for Medicare and Medicaid Services and other payers shift to value-based care versus volume-based reimbursement. We have to figure out how to make the switch and meet all the payer requirements while staying within the rules in order to stay afloat," Roberson says.

In addition to participating in the voluntary Bundled Payment for Care Improvement initiative from CMS, the 540-bed research and teaching hospital has taken a leadership role in two statewide projects aimed at providing healthcare for the uninsured and underinsured, and preventing readmissions and ED visits for at-risk Medicaid patients with chronic conditions.

The hospital kicked off its first bundled payment initiative in July 2015 as part of the CMS voluntary initiative.

"Bundled payments provide a great platform for moving into the new era of healthcare. The initiative requires hospitals to reach out to other providers and work together to provide high-quality, cost-effective patient care," Roberson says.

The health system has a post-acute division that includes a long-term acute care hospital, a skilled nursing facility, home health, and hospice services.

"Working within our own system has helped us understand how providers across the continuum work. We've also been working with skilled nursing facilities outside our hospital system for many years, and meet with them quarterly. These experiences are helping us move forward," she says.

Spartanburg Regional Healthcare System was the first system in South Carolina to sign up for the Access Health program, a project sponsored by the South Carolina Hospital Association to encourage community organizations to collaborate on ways to provide healthcare for the uninsured and underinsured. The health system began the program six years ago as part of its goal to connect low-income patients to healthcare.

"AccessHealth has given us a chance to explore community

partnerships and collaborations, and to develop the relationships we need to provide the best care for our patients," Roberson says.

The program links uninsured patients to primary care providers who have agreed to provide free or low-cost ongoing care. The staff works closely with the patients to help them overcome any obstacles to leading a healthy lifestyle.

"Our mission is to provide preventive care and treatment for clients who are uninsured. The challenge and the ultimate goal for us is, 'How do we collaborate to effectively hand off patients from the inpatient setting to the ambulatory setting and connect with all of the entities in the community?'" she adds.

The staff includes non-clinicians who are trained as eligibility specialists, RN care navigators, social worker care navigators, and volunteers from the AmeriCorps program.

Community partners include both hospitals in Spartanburg, a free medical clinic, a federally qualified health system, the public health department, the department of mental health, the alcohol and drug abuse commission, the county medical association, and a statewide medication program.

AccessHealth received a grant in July from the Robert Wood Johnson Foundation as part of its Transforming Complex Care initiative. The grant will help pay for a new community health worker to work closely with high-risk, high-cost individuals.

The target population is low-income, uninsured people who use the ED frequently. A large portion of the population has behavioral health issues, including mental health problems, alcohol or drug abuse, or all three, Roberson says.

"Behavioral health was one of the driving threads of AccessHealth, but many of these patients have other health issues such as diabetes and cardiovascular disease," she says.

Referrals come from the hospital, community organizations, and through self-referrals. Participants have to meet income requirements and be without insurance.

When people are referred to the program, the care navigation team conducts an assessment to determine their eligibility for AccessHealth as well as other local, state, and national programs. "Sometimes they find that clients are eligible for Medicaid, the Supplemental Nutrition Assistance Program [SNAP], or other programs. In those cases, a care navigator helps them sign up," Roberson says.

The care navigators screen participants for behavioral health issues and psychosocial needs, helping them access assistance from community agencies. They help participants identify a primary care provider who can meet their needs, and who has agreed to provide care for uninsured clients. They also work with the clients to set goals and support them in meeting their goals, Roberson says.

The program addresses clients' social needs, as well as helping them navigate the healthcare system. The program cut hospital use by 31% and reduced costs by 42% among AccessHealth participants in 2014, according to AccessHealth's report to the community.

When the care management team assessed the first group of patients, using a patient engagement scale, they found that the majority of patients scored very low when it came to being engaged in their own health. For that reason, a member of the care management team attends the first primary care appointment and the first mental health appointment with participants and may attend other appointments.

"These people have so many barriers to healthcare that there is a big risk that they won't be successful in taking care of their own health. We coach them before the first

## EXECUTIVE SUMMARY

Spartanburg (SC) Regional Healthcare System is partnering with providers at other levels of care and in the community to improve care for Medicaid patients and the uninsured.

- Access Health focuses on low-income and uninsured people who frequently use the ED for primary care issues. Many patients also have behavioral health issues.
- Access Health includes eligibility specialists, RN care navigators, social worker care navigators, and volunteers from the AmeriCorps program to connect patients with primary care providers who charge a discounted rate, address their social needs, and coach them on navigating the healthcare system.
- Case management is a major component of Healthy Outcomes, a collaboration of the three hospitals in Spartanburg. The staff works closely with the patients to help them overcome the obstacles to receiving primary care, educates them on appropriate use of the ED, and accompanies them to physician visits.

appointment and during their encounters with providers," she says.

The care managers spend a lot of time preparing their clients for their first physician visit. "It's a lot of work. Most have no idea how to navigate the healthcare system. Many feel ashamed because they don't have insurance. The care managers assist them in writing down a list of questions they want to ask their doctors," Roberson says.

Participating physicians have expressed approval of having a member of the care management team attend office visits, Roberson says.

The program received the city of Spartanburg's 2015 Culture of Healthcare Prize honoring communities that are improving the health of their residents, and the program was cited by the Robert Wood Johnson Foundation.

Roberson is the clinical liaison for Healthy Outcomes, a program launched in 2013 by South Carolina's Department of Health and Human Services to reduce inappropriate use of hospital ED services and cut costs in the state Medicaid program. Participants must have one or more chronic conditions, be uninsured, and utilize the ED frequently.

"Because patients don't have a primary care provider, they often go to the emergency center when they are sick. People with chronic conditions are among the most frequent users of the emergency center. Healthy Outcomes staff works closely with the patients to help them overcome the obstacles to receiving primary care and educates them on appropriate use of the emergency center," Roberson says.

The program is staffed by three registered nurses, one medical social worker, and two clinical social workers. They accompany clients to physician visits, see them in their homes when needed, and help them link with community organizations.

"More than anything, the Healthy Outcomes program is about case management and transitions and value-based care that ties back to the community. We believe our system has developed relationships with community agencies that allow us to collaborate with each other on meeting the needs of the people in our community," she says.

Healthy Outcomes is a collaboration of the three hospitals in Spartanburg, two of which are part of Spartanburg Regional Healthcare System, and is managed by AccessHealth. Roberson serves as the clinical link for the Healthy Outcomes program.

The hospitals identify patients for the Healthy Outcomes program in the ED, but typically, patients know someone who is enrolled in the program and they refer themselves, Roberson says.

"Nonprofit organizations are very familiar with Access Health. There are a lot of cross-referrals. We refer patients to the community organizations and they also refer appropriate patients to use," Roberson says. ■

# Get Ready to Give Your Patients the MOON

*Form is required for observation patients*

Hospitals should start now to determine what internal processes they will use to deliver the Medicare Outpatient Observation Notice (MOON) to notify patients when they are receiving observation services, advises **Teresa McNulty**, RN, BA, ACM, IQCI, director at Huron Consulting Group, a Chicago-based healthcare consulting firm.

In the 2017 final rule for the Inpatient Prospective Payment System (IPPS), CMS set Oct. 1 as the date hospitals should begin delivering the MOON. CMS asked for public comment on the required form, which has delayed implementation, probably until late fall, McNulty says. The 30-day comment period closes Sept. 1. The Office of Management and Budget (OMB) must review and approve the final version. After that, hospitals have 90 days to implement it.

"Until hospitals have the required form, they can't begin implementing the requirement," McNulty says.

The Notice of Observation Treatment and Implication for Care Eligibility Act, passed by Congress on Aug. 8, 2015, requires hospitals, including critical access hospitals, to provide written and oral notification to patients receiving observation services for more than 24 hours. Hospitals must deliver the notice no later than 36 hours after observation services begin.

Hospitals must use a standardized notice and fill in the specific reason the patient is not an inpatient. CMS does not offer any standard language for the clinical reason patients are not inpatients, but leaves a blank to fill in, McNulty points out.

## EXECUTIVE SUMMARY

Hospitals should start now to develop a process to deliver the Medicare Outpatient Observation Notice (MOON), alerting patients that they are receiving observation services and informing them of their potential financial responsibilities.

- CMS announced in the Inpatient Prospective Payment System final rule that hospitals must deliver the MOON to all patients receiving observation services for more than 24 hours, provide an oral explanation of why they are in observation, and get the form signed.
- Hospitals will have to use a standard form that includes the reason the patients are receiving observation services instead of being admitted, the potential for out-of-pocket expenses, and that observation stays do not count toward the three-day requirement for Medicare to pay for a skilled nursing facility.
- The requirement goes into effect 90 days after the form is approved by the Office of Budget and Management, which is anticipated to be late fall.

The standardized form explains the implications of receiving outpatient services, including the potential the patient will have out-of-pocket costs and how an observation stay affects the eligibility requirements for Medicare to cover a skilled nursing facility stay. Hospitals also are required to provide an oral explanation of what the notice means, preferably at the same time the written notice is delivered.

"Hospitals should identify how they will meet all of the elements of the rule and be ready to do so when the form is approved," she says. Determine who fills in the form, who delivers it, how and when it's delivered, and how it is documented, she says.

Some hospitals have the patient access department staff deliver the notice at the time the patient is registered, McNulty says. Others deliver it in the ED once the physician issues the order for observation services. However, CMS has issued guidance that the form should not be given at the beginning of the stay when there is a lot going on, although it says hospitals may issue the form before the patient has received services for 24 hours, she adds.

Patients must sign the form and should get a copy for their records.

The MOON requirement creates a double burden on providers in some states, where there is a state requirement to notify patients they are receiving observation services that may be different from the Medicare requirement, McNulty point out.

CMS has not announced the penalties for not delivering the MOON, McNulty says. Hospitals are unlikely to be audited specifically for delivering the MOON, but any lapses may be uncovered when hospitals are audited for compliance and billing, she adds.

The draft of the MOON document is available at: http://go.cms.gov/2bcGnlJ. ■

# Compressed Work Shifts Put Nurses at Risk

*Lack of recovery time dulls reactions*

Nurses appear to be at higher risk of injury as they suffer a kind of cumulative fatigue and diminishment in balance and reactions working "compressed" shifts, researchers report.[1]

Regardless of day or night shift, nurses working three 12-hours stints within a four-day period showed measurable diminishment in motor skills and increase in musculoskeletal disorders, the study found. The overall effect of this fatigue heightens risk for injury by slips and falls while putting patients at risk of medical errors.

"Evidence is mounting that the more rigorous work schedules yield unfavorable effects on the worker and on the quality of care," says lead author **Brennan J. Thompson**, PhD, assistant professor of kinesiology at Utah State University in Logan. "More effort is needed to regulate the volume of work performed within a given time period."

Some researchers argue that 12-hour shift schedules are a major part of the problem, suggesting that shorter work shifts would help resolve some of the poor health and work-related issues of nurses, he says.

"If the 12-hour shift schedule is unable to be avoided, efforts should be made to spread the work shifts across a longer time period, allowing greater recovery between shifts," Thompson says.

For example, nurses could consider spreading their shifts across a greater number of days, such as working three shifts over a five-to-seven-day period.

"It may be prudent for nurses to work no more than two shifts in a row and to allow a minimum of two days of recovery days off following two work shifts," he says. "Fatigue, and ultimately burnout, occur when there is an imbalance of work volume performed relative to recovery."

For successive shifts — two or more — one day off for recovery is likely insufficient to restore performance. If recovery time is lacking, chronic fatigue may set in along with impaired mental and physical performance on a long-term basis, he warns.

Sticking strictly to the science, it is not possible to say exactly what is causing the problem or account for all variables between day and night shifts. Regardless of shift, nurses working three 12-hours stints within a four-day period showed measurable diminishment in motor skills and increase in musculoskeletal disorders. This corrected the original hypothesis to some degree, as researchers thought night shift workers would have increased musculoskeletal disorders or poorer response times than their day shift colleagues.

"Our study findings did not show differences in fatigue responses between day and night shift workers for a time-matched work intervention," Thompson says. "This may suggest that fatigue develops in nurses independent of the type of shift worked, when working long hours in a successive work shift pattern."

However, this does not pinpoint the exact sources of the fatigue, so "the possibility remains that unique characteristics to each shift type are contributing differently to the similarly observed performance declines," he says.

The prevailing but unproven theory is that workers on compressed shifts lack "recovery time," and thus suffer diminished abilities as they wear down, he says.

"The current body of research is not complete in this regard," Thompson says. "More work is needed to identify and characterize the root causes of worker fatigue as a result of demanding work schedules. An appealing hypothesis is the lack of opportunity for a full recovery of performance prior to the next successive shift."

It's certainly an area in need of some answers, as nurses are an unfortunate No. 1 annually when non-fatal occupational injuries are tallied. In addition, only workers in the warehouse and transportation sector have more musculoskeletal disorders than nurses.

"This alarming statistic is particularly impactful when considering that the healthcare industry comprises one of the largest portions of the labor force (12%, 17 million workers), and is projected to experience the highest growth of any other industry in the upcoming years — adding 5 million jobs through 2022," Thompson and co-authors reported in the paper.

The most commonly reported injuries in nurses are of the musculoskeletal variety, with leading causes including overexertion, slips, trips, and falls. Delayed response and fatigue impairments could hinder rapid responses needed to recover from a slip or a sudden patient movement that could result in a needlestick or other injury.

"[T]hese predominant causes of injury may be largely preventable, particularly because they are factors that are influenced by the individual-environment dynamic," the authors reported. "For example, improvements in individual health and performance abilities [through] reduced fatigue, improved body mass index, enhanced response time, muscular strength, [in addition to better] work scheduling patterns, availability of mechanical lifting aids, etc., would likely diminish risks."

The researchers used a questionnaire to find the prevalence of musculoskeletal disorders and fatigue effects. Nurses working three 12-hour work shifts in a four-day period were then tested for balance, reaction time, and other measures after the work period.

"A key feature of this study was that these changes were demonstrated objectively using physical performance-based measurements, and not solely based off of self-reported or perceived functional status," the authors concluded. ■

## REFERENCE

1. Thompson BJ, Stock MS, Banuelas VK, et al. The Impact of a Rigorous Multiple Work Shift Schedule and Day Versus Night Shift Work on Reaction Time and Balance Performance in Female Nurses: A Repeated Measures Study. *Jrl Occ Environ Med* 2016;58(7):737-743.

## COMING IN FUTURE MONTHS

- Transition initiatives that really work
- Making the most out of PEPPER
- What the Recovery Auditors are looking for
- Balancing patient choice and preferred providers

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# CE QUESTIONS

**1. With bundled payments, hospitals need to follow the patients for up to 90 days post-acute and monitor the quality of care they're receiving along with their resource utilization, according to Cheryl Warren, MS, RN, CMAC.**

A. True
B. False

**2. In the Healthy@Home program created by Rockdale Medical Center and National EMS, how often does the program's paramedic visit participants to perform a health check and educate them about their diseases?**

A. Within 72 hours of discharge, then every five days.
B. Once a week for the first month, tapering off as patients feel confident to care for themselves.
C. Once a week for four weeks, then once a month for six months.
D. It depends on the patient and his or her needs.

**3. When the team at Spartanburg, SC's AccessHealth program administered a patient engagement assessment for low-income, uninsured, frequent ED users in the program, they found that the majority of patients scored very low when it came to being engaged in their own health. What action did the team take?**

A. Coached the patients on learning to navigate the healthcare system.
B. Helped patients make a list of questions to ask during their appointments with providers.
C. Accompanied them to their first primary care, specialist, or behavioral health visits.
D. All of the above.

**4. What deadline has CMS set for hospitals to start giving the Medicare Outpatient Observation Notice (MOON) to patients who have received observation services for 24 hours or more?**

A. Within 90 days after the Office of Management and Budget approves the required form.
B. October 1, 2016.
C. January 1, 2017.
D. September 1, 2016.