HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Get On the Bundled Payments Bandwagon — Even if Your Hospital Isn't Participating

The 'same old, same old' won't cut it with the focus on quality

If your hospital isn't already participating, or planning to participate, in a bundled payment arrangement, it could be at a disadvantage in the future as payers increase emphasis on cutting costs and improving quality.

The Centers for Medicare & Medicaid Services (CMS) currently is screening applicants for the new Bundled Payments for Care Improvement (BPCI) Advanced model, which includes 29 inpatient clinical episodes and three outpatient clinical episodes. The voluntary program begins Oct. 1.

> "THE COST OF HEALTHCARE HAS TO COME DOWN. THE AIM OF BUNDLED PAYMENTS IS FOR PATIENTS TO RECEIVE BETTER CARE AND BETTER VALUE, BUT AT A LOWER COST."

"Hospitals either have to get on board with bundled payments or be left out in the future. Medicare is making it voluntary, but hospitals that don't participate and keep on doing the same old thing without cost containment are going to lose in the end," says **Donna Hopkins**, MS, RN, CMAC, a case management consultant based in Boerne, TX.

Many of the previous bundled payment initiatives have shown that the same level of service — and often better outcomes — can be provided for a lot less money, Hopkins adds. "The cost

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of healthcare has to come down. The aim of bundled payments is for patients to receive better care and better value, but at a lower cost," she says.

"Cost containment has begun to be the driving force for improving care now that it's affecting reimbursement," she adds. "Not only is the bottom line affected by direct costs vs. income, there are added incentives and penalties."

The new administration has made a lot of changes in the bundled payments program and other CMS initiatives, states **Brian Pisarsky**, RN, MHA, ACM, director at KPMG Healthcare Solutions. "But one thing is clear: Value-based arrangements are not going away," Pisarsky says.

"Historically, when CMS comes up with a voluntary program, it's likely to become mandatory," says **Beverly Cunningham**, RN, MS, ACM, consultant and partner at Oklahoma-based Case Management Concepts.

However, she points out that Alex Azar, the new Department of Health and Human Services (HHS) secretary, has made it known that he is not a fan of mandated bundled payments. "Regardless, case managers still need to become efficient, even if their hospital isn't participating in this round of bundled payments. The next application period is in 2020 and they should start preparing for the next round, should their executive leadership decide to participate," she adds.

Bundled payments are not expected to go away, says **Teresa Marshall**, RN, MS, CCM, senior managing consultant for Berkeley Research Group.

"These are just simply the latest wave of bundled payments. The payments started in 2013 with a second round beginning in 2015, and now CMS has announced the advanced bundles for 2018," she says.

CMS's previous leadership made participation in a group of cardiac and orthopedic bundled payments mandatory, but the agency's new leadership canceled them a few weeks before they were to go into effect.

But hospitals that have prepared for the programs didn't waste their time, Marshall points out. "Even if they chose different clinical programs for the new program, they have experience in developing the process and are aware of how the components work. They can take this knowledge and apply it to other

EXECUTIVE SUMMARY

Even though the latest rounds of bundled payments are voluntary, the shift toward value-based reimbursements continues — meaning hospitals and their case management staffs still should focus on improving patient care, reducing readmissions, and containing costs at the same time.

- Be aware of the costs of services and use the information to recommend the most cost-effective discharge plan that should produce good outcomes.
- Use retrospective data from each service line to identify areas where your process can be improved and track data in real time to monitor your progress and make any necessary changes.
- Work with a cross-continuum, multidisciplinary team to design protocols that standardize care across levels of care, create reports on team and individual performance, and share the information to improve the program.

bundled payment initiatives," she adds.

Healthcare is shifting from volume to value, points out **Ken Steele**, principal with ECG Management Consultants. "It's all about improving quality of care and the patient experience, all within a value-based realm. All payers, not just Medicare, are holding providers accountable for improving value," he says.

Health systems with goals of improving care delivery and reducing costs are likely to seize the opportunity to be rewarded for value and have signed up to participate in the new bundled payments program, Steele says.

If the models become mandates, health systems that don't already have experience with bundled payments are going to be at a disadvantage, Steele adds.

CMS has designated two types of participants for the BPCI Advanced program: conveners and nonconveners, Cunningham says. Conveners work with downstream entities and are at risk for the entire episode of care. Nonconveners are at risk only for the services they provide.

Participants will be paid regular Medicare fee-for-service rates. The costs will be compared to a target price determined by CMS and the providers will either receive a bonus or pay a penalty, depending on their results. CMS will distribute the target prices to hospitals in May and will offer participant agreements to applicants in June, according to **Susan Wallace**, MEd, RHIA, CCS, CDIP, CCDS, director of inpatient compliance for Administrative Consultant Services, a Shawnee, OK-based healthcare consulting firm.

CMS has announced that it will calculate each hospital's benchmark prices for each clinical episode using risk-adjusted models that take into account patient case mix, patterns of spending relative to the hospital's peer group, and historical Medicare fee-for-service efficiency in resource use during the baseline period, which runs from Jan. 1, 2013-Dec. 31, 2016. The bundled payment performance period starts Oct. 1 and runs through Dec. 31, 2023, Wallace adds.

The bundled payments initiative is geared to Medicare patients, but the improvements in the patient care process will improve care delivery for all patients, Steele says.

"In addition to making sure that patients have a great experience in the hospital, case managers have to make sure they have a successful recovery throughout the continuum," Steele says.

The goal of bundled payments is to provide care at higher quality and lower costs, says **John Wagner**, associate director at Berkeley Research Group.

"It is a benefit to all when patients receive more efficient and cost-effective care," he says.

Case managers have significant influence over other disciplines in containing the cost of care, Hopkins points out. "The shift toward value-based reimbursement and other changes in the healthcare arena put case managers behind the 8-ball," Hopkins says.

Case managers should be aware of the cost of individual services and recommend the most cost-effective choices, Hopkins says. "The new case management mantra is 'why not home,' whenever it is safely possible. Avoiding a costly post-acute placement, or keeping a patient in the acute care setting an extra day or two in order to avoid a rehab stay, can significantly influence costs," she says.

The new emphasis on cost-effective care means case managers are going to have to be more strategic than ever, Cunningham says. Case management leadership should make sure their staff understands what bundled payments mean to their hospital's bottom line and keep the case management staff up on all the new rules and regulations that come down the pike, she adds.

"Case managers are going to have to be very innovative in discharge planning and care coordination and to have a sense of urgency in moving patients through the continuum," she adds.

It's important for case management directors to understand the bundled payments process so they can ensure that the case management model is sufficient enough to handle the program, Marshall says.

It's not too soon to start preparations for the new program, Pisarsky says. Case managers should verify the bundled payment contracts the hospital already has in place, as well as those in the new program that leadership is applying for, he adds. Then, gather data on past performance so you can make improvements on your processes before the program — and the hospital's financial risk — begin, he says. *(For more information on gathering data and how to use it, see related article on page 49.)*

Hospitals can no longer afford to look at patient care retrospectively. They need to be aware of everything in real time to get a better handle on the cost — and that is the role of case management, Hopkins says.

It's no longer enough to assess patients within 24 hours, Pisarsky says. "Case managers need to start on discharge planning on hour 1," he adds.

That means case managers must assess the patient's living situation

and support on the day he or she is admitted, Steele adds.

He suggests developing a screening checklist to determine what the patient will need after discharge. "Case managers, therapists, home health providers, and physicians should collaborate on a checklist that assesses the home setting, including physical obstacles like stairs, family or other support, [and the] patient's ability to perform activities of daily living and safely live independently," Steele recommends.

Bundled payments mean hospitals must place case managers at all entry points — the ED, admissions, the transfer center, and surgery, Cunningham says.

In the current hip and knee bundled payments program, the surgeries were scheduled and case managers would have been able to start planning discharges in advance, Cunningham points out. But the new initiative includes many medical diagnoses, and those patients are likely to be seen in the ED, she adds.

"It's more important than ever for hospital leaders to understand the value of having case managers in the emergency department up to 24 hours a day, seven days a week, knowing it will be expensive. But, when the hospital faces financial risk, case managers are going to have to increase collaboration with emergency department physicians — who are the primary group of collaborative admitters [physicians who collaborate with admitting physicians] in most hospitals," Cunningham adds.

Staffing case managers in the ED 24 hours a day, seven days a week is ideal, but it's not practical for some hospitals, Pisarsky says. In those cases, case managers should be present when most of the ED admissions take place, he adds.

Track your admissions and when they occur, and staff accordingly. "You don't want to have a case manager on duty from 9 a.m. to 5 p.m. if most of the admissions occur from 4 p.m. to midnight," Pisarsky adds.

Case managers should assess patients on admission, and not the next day. They should determine the expected discharge date on admission, and understand if the patient needs complex discharge planning and when to bring in a social worker, Cunningham says.

Bundled payments and other pay-for-performance programs make it essential for case managers to track avoidable days so hospital leadership can understand where the delays are occurring, why they are occurring, and who is involved, Cunningham says.

"All of this cannot happen if case managers have such a large caseload that they are not able to have a sense of urgency. Case managers are only as effective as their caseloads. When their caseload is high, all case managers are doing is reacting and they have to be proactive," she says.

"Case management directors can teach their staff about what they need to do, but if their caseloads are large, all they are doing is scrambling every day," she says.

It's important for case managers to stay current on what is going on in healthcare, Cunningham says. She suggests participating in webinars, reading about what CMS has decreed, and attending a national meeting, if possible.

"Case managers can't avoid educating themselves on the latest in healthcare. Case management is becoming a more dynamic role that is ever-changing and, like it or not, individual case managers have to change to keep up," Cunningham says. ■

It Takes Collaboration and Consistency for Success in Bundled Payments

Cross-continuum, multidisciplinary committee should oversee the process

It takes a lot of planning and oversight for hospitals to succeed financially under bundled payment initiatives, which work best when representatives from all levels of the healthcare continuum work together, says **John Wagner**, associate director at Berkeley Research Group.

"The new Bundled Payments for Care Improvement Advanced program is an opportunity for hospitals, physicians, and post-acute providers to work collaboratively to improve the quality of care," says **Ken Steele**, principal with ECG Management Consultants.

Program participants are responsible for the entire episode, up until 90 days post-acute, which makes collaboration among everyone who touches the patient imperative, he adds.

"There's always a learning curve as new systems go into place. There

has to be a committee that oversees the process and makes changes to improve it," Steele says. The hospital staff on the committee should include representatives from admission, nursing, surgery, the medical floors, and IT, as well as the physician champion of the service line the bundle is in, he adds.

The role of the oversight committee should be to review the contracts, collect and analyze data, and identify the opportunities the hospital would have, says **Brian Pisarsky**, RN, MHA, ACM, director at KPMG Healthcare Solutions. The physician champion from each service line involved in the project should make sure the team stays on track and risks to the hospital are mitigated, he says.

Case management consultant **Donna Hopkins**, MS, RN, CMAC, suggests setting up service line-specific committees for each grouping of clinical episodes with common elements. For instance, there are multiple clinical episodes in the program that fall into the category of cardiac diagnoses. There also are several orthopedic and gastrointestinal diagnoses that can be grouped together for the purpose of oversight, she says.

"Representatives from all levels of the healthcare continuum must work together to eliminate duplication and reduce waste," she says.

Bring together all stakeholders from across the continuum and work together on best practices. Look for ways to reduce costs, and monitor progress, she says. Case managers should be active participants in the committee, she adds.

Hopkins suggests that hospitals review the roles and responsibilities of everyone who will touch the patient during the 90-day episode of care and identify any duplications. Make changes to eliminate any duplication.

One frequent source of duplication is post-discharge phone calls. In some instances, they are being conducted by nurses or case managers, patient navigators, and pharmacists in the hospital setting as well as case managers from insurance companies and physician offices. "Not only is this an inefficient duplication of services, it also annoys patients when they get multiple phone calls asking the same questions," Hopkins says. ■

Use Data to Identify Opportunities, Monitor Progress to Make Bundled Payments Work

Start now to prepare for program kick-off

Success under bundled payments requires using past data to identify opportunities for improvement and analyzing current trends to uncover problematic situations and make changes in real time, according to **Brian Pisarsky**, RN, MHA, ACM, director at KPMG Healthcare Solutions.

Case management leadership should start collecting data now to understand where opportunities for improvement lie, Pisarsky suggests. "What's required under bundled payments isn't something new — it's just a new way to pay for care," Pisarsky says.

Use historical data to plan for the future, Pisarsky suggests.

"The key to succeeding under bundled payments is to use data from the past to determine what physicians, hospital leadership, and case management leadership need to do differently to improve the cost per case and improve patient outcomes," Pisarsky says.

Review the data for several months so you'll be aware of any issues to tackle before BPCI Advanced kicks off, he adds.

If your hospital already uses bundled payment arrangements, analyze them to see how you're doing. Otherwise, analyze the past cases that would fall into a bundle your hospital is applying for and determine whether the hospital would have won or lost financially under bundled payments. Go back six months or a year and make case-by-case examinations, then drill down on the outlier cases to see what you could improve.

One of case management's important roles in a bundled payment program is to manage resource consumption, says **Teresa Marshall**, RN, MS, CCM, senior managing consultant for Berkeley Research Group. This means case managers must know the cost of services as well as the target length of stay, she says.

Now more than ever, hospitals must employ data analysts to help them understand the costs, says **Beverly Cunningham**, RN, MS,

ACM, consultant and partner at Oklahoma-based Case Management Concepts.

"When the new bundled payments program starts, case managers will need to be more cautious about how much is spent and how long the patient stays. The case manager should analyze all charges and costs and compare the cost of care to the target price," Cunningham says.

Case managers should know the length of stay and cost for each component of each bundle the hospital leadership chooses. "They need to have intense data analysis and know exactly what they are taking on," she says.

Look at the trends over the past year and compare past costs to price targets set by CMS, then look for ways to lower costs, she says.

After the October start of the program, immediately start collecting and analyzing data and looking at patterns and trends, Pisarsky says. "If one bundle has a lot of readmissions, or the length of stay starts creeping up, it's helpful to know early on so you can make immediate changes toward improved outcomes," he says.

Make sure the entire staff understands their role in the new system, Pisarsky says. This likely means multiple educational sessions for ED case management staff as well as inpatient social workers and case managers, he adds.

Data are extremely important to the success of a bundled payment program, Marshall says. Case managers should collect data about every bundled payment and manage it as closely as possible, she says.

"Case managers need to analyze readmissions, drill down to find the cause, and come up with a solution to prevent the next one, and make changes as soon as possible after readmissions are identified," she says.

Case managers should work with their counterparts in physician offices and post-acute providers to reduce variation in reporting so data will be complete, adds **John Wagner**, associate director at Berkeley Research Group.

It's essential for case managers to have recent data when they take up an issue with a provider or their physician advisor, Marshall says.

When your data reveal outliers whose outcomes are not on par with those of their peers, show them data that compare their results to other clinicians' data, Wagner adds.

"If the bundled payment program works as designed, every individual or organization that delivers care that is following the protocols and clinical pathways should have better outcomes data than those who choose to do it their own way. Data is a strong tool to use with the more reticent providers to convince them to change their methods," Wagner states. ■

Improve Your Outcomes by Reducing Variations in Care

Cross-continuum team should develop protocols

Standard practices produce better results, says **Ken Steele**, principal with ECG Management Consultants.

With bundled payments and other quality initiatives, hospitals should constantly improve their processes, Steele says. "When the variations are removed from the system, it increases the quality of care across the board," he says.

He recommends that a multidisciplinary team from the hospital work with community physicians and post-acute providers to develop protocols. One of the main focuses of the committees should be reducing variation by developing an evidence-based process to follow with each bundle, he adds.

For instance, standard processes allow case managers and nursing to inform patients and family members up front about what is going to happen, he says.

The entire clinical team should be involved in designing protocols, says **Teresa Marshall**, RN, MS, CCM, senior managing consultant for Berkeley Research Group.

"Anyone involved within the 90-day period covered by the bundled payment contract should be involved in the process. If everyone who will be involved with patients participates in the development of the plan, they're more likely to buy into it," she adds.

The stakeholders on the oversight committees should work together to develop protocols that are based on best practices and standardize care provided by all disciplines across the continuum, says **John Wagner**,

(continued on page 55)

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

Compliance Measures for the Case Manager's Daily Practice — Part 3

By Toni Cesta, PhD, RN, FAAN

Introduction

In the last two issues, we reviewed the areas of compliance in the Conditions of Participation (CoP) for utilization review and began our discussion on the CoP for discharge planning. In this issue, we will continue our discussion of the areas of compliance for discharge planning.

CoP and Patient Choice

In section c(6) of the discharge planning CoP is the explanation of the requirements related to post-discharge services and patient choice. Many hospitals either have overinterpreted this section or underinterpreted it. This is one area that can easily be audited by any surveyor and can affect the hospital's recertification. The hospital must include in the discharge plan a list of home health agencies (HHAs) or skilled nursing facilities (SNFs) that are available to the patient, meaning that they provide the services that the patient needs and have an available bed. In addition, they must be participating in the Medicare program, and must serve the geographic area (as defined by the HHA) in which the patient resides. In the case of a skilled nursing facility, it must be in the geographic area requested by the patient.

AT THIS TIME, HOME HEALTH AGENCIES AND SKILLED NURSING FACILITIES ARE THE ONLY TWO POST-ACUTE SERVICES THAT MUST BE LISTED AND PROVIDED TO THE PATIENT.

At this time, home health agencies and skilled nursing facilities are the only two post-acute services that must be listed and provided to the patient. While you may give your patients choices for other services, you are not legally required to do so.

It also is required that the hospital documents in the medical record that the list was presented to the patient or an individual acting on the patient's behalf. It does not require that you put the list in the medical record, only that you document that it was given to the patient.

For patients enrolled in managed care organizations, the hospital must indicate the availability of home health and post-hospital extended care services through individuals and entities that have a contract with the managed care organization.

When providing the list to the patient, the hospital is required to inform the patient, or his or her representative, of the freedom to choose among participating Medicare providers of post-hospital services and must, when possible, respect the patient and family's preferences. If their preference is not available, the hospital can move on to their next choice. Of course, it always is best to give the patient his or her first choice, but if there is a delay in availability, the hospital cannot allow this delay to extend the length of stay. When this happens, the case manager should explain the issue to the patient and family so that they clearly understand the situation and select their second choice if they haven't already done so.

Interpretive Guidelines

Listed below are guidelines that can be used to interpret discharge planning regulations. By following these guidelines, you and your department can ensure that you are compliant with them. *(Compiled from Medicare's Conditions of Participation: Discharge Planning, CMS, 2014.)*

§482.43: Discharge Planning

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

This CoP applies to all types of hospitals and requires them to conduct appropriate discharge planning activities for all patients who are admitted to the hospital as inpatients, except for those who are cared for in the ED but are not admitted as hospital inpatients. The written discharge planning process must reveal a thorough, clear, comprehensive process that is understood by the hospital staff.

Adequate discharge planning is essential to the health and safety of all patients. Patients may suffer adverse health consequences upon discharge without benefit of appropriate planning. Such planning is vital to mapping a course of treatment aimed at minimizing the likelihood of readmission that could have been prevented.

• §482.43(a): Identification of Patients in Need of Discharge Planning. The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

The hospital must set the criteria for identifying patients who are likely to suffer adverse health consequences upon discharge without adequate discharge planning, considering factors such as functional status, cognitive ability of the patient, and family support. Patients at high risk of requiring post-acute services must be identified through a screening process.

The hospital should re-evaluate the needs of the patients on an ongoing basis, and prior to discharge, as they may change based on the individual's status.

There is no set time frame for identification of patients requiring a discharge planning evaluation, other than it must be performed as early as possible. The timing is left up to the hospital and its staff.

§482.43(b): Discharge Planning Evaluation

The post-discharge needs assessment can be formal or informal and generally includes an assessment of the patient's post-discharge needs. These may include assessment of psychosocial needs, the patient's and caregiver's understanding of discharge needs, and identification of post-hospital care resources.

• §482.43(b)(1): The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.

The purpose of a discharge planning evaluation is to determine continuing care needs after the patient leaves the hospital setting.

• §482.43(b)(2): A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.

The responsibility for discharge planning is multidisciplinary and not restricted to a particular discipline. The hospital has flexibility in designating the responsibilities of the registered nurse, social worker, or other appropriately qualified personnel for discharge planning. The responsible personnel should have experience in discharge planning, knowledge of social and physical factors that affect functional status at discharge, and knowledge of community resources to meet post-discharge clinical and social needs.

• §482.43(b)(3): The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services, and of the availability of the services.

The hospital is responsible for developing and implementing the discharge plan. The hospital's ability to meet discharge planning requirements is based on the following:

- implementation of a needs assessment process with identified high-risk criteria;
- evidence of a complete, timely, and accurate assessment;
- maintenance of a complete and accurate file on community-based services and facilities, including long-term care, sub-acute care, home care, or other appropriate levels of care to which patients can be referred;
- coordination of the discharge planning evaluation among various disciplines responsible for patient care.

• §482.43(b)(4): The discharge planning evaluation must include an assessment of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

The capacity for self-care includes the ability and willingness for such care. The choice of a continuing care provider depends on the self-care components, availability, willingness, and ability of family/caregivers, and the availability of resources. The hospital must inform the patient or family of their freedom to choose among providers of post-hospital

care. Patient preferences also should be considered; however, preferences are not necessarily congruent with the capacity for self-care.

Patients should be evaluated for return to the prehospital environment, but also should be offered a range of realistic options to consider for post-hospital care. Hospital staff should incorporate information provided by the patient and/or caregivers to implement the process.

• §482.43(b)(5): Hospital personnel must complete the evaluation in a timely manner so that appropriate arrangements for post-acute care are made before discharge, and to avoid unnecessary delays in discharge.

The timing of the discharge evaluation should be relative to the patient's clinical condition and anticipated length of stay. Assessment should start as soon after admission as possible and be updated periodically during the episode of care.

Information about the patient's age and sex could be collected on admission while functional ability data is best collected closer to discharge, indicating more accurately a patient's continuing care requirements.

The hospital must demonstrate its development of discharge plan evaluation for patients in need and discuss the results of the evaluation with the patient or individual acting on his or her behalf.

• §482.43(b)(6): The hospital must include the discharge planning evaluation in the patient's medical record in order to create an appropriate discharge plan, and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.

The discharge plan evaluation should be documented in the patient's record. The hospital is expected to document its decision about the need for a plan and indicate what steps were taken to implement the plan. Evidence of an ongoing evaluation of discharge planning needs is an important factor of documentation.

Documented evidence of discussion of the discharge planning evaluation with the patient, if possible, and interested persons should exist in the medical record. It is preferable that the hospital staff seek information from the patient and family to make the discharge planning evaluation as realistic and viable as possible.

The hospital CoP at §482.13(b): Patients' Rights states that "The patient has the right to participate in the development and implementation of his or her plan of care." CMS views discharge planning as part of the patient's plan of care. "The patient or his/her representative (as allowed under state law) has the right to make informed decisions regarding his/her care" and "The patient's rights include ... being involved in care planning and treatment."

§482.43(c): Discharge Plan

The hospital must ensure that the discharge plan requirements are met. It is a management function of the hospital to ensure proper supervision of its employees. Existing training and licensing requirements of a registered nurse and social worker in discharge planning are sufficient. "Other appropriately qualified personnel" may include a physician.

• §482.43(c)(1): A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the evaluation indicates a need.

The hospital should determine who has the requisite knowledge and skills to develop the plan. However, because post-hospital services and, ultimately, the patient's recovery and quality of life can be affected by the discharge plan, the plan should be supervised by qualified personnel to ensure professional accountability.

• §482.43(c)(2): In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan. In such a case, the hospital must develop a discharge plan for the patient.

The physician can make the final decision as to whether a discharge plan is necessary. The hospital will develop a plan if a physician requests one, even if the interdisciplinary team determined it is unnecessary.

• §482.43(c)(3): The hospital must arrange for the initial implementation of the patient's discharge plan.

This includes arranging for necessary post-hospital services and care, and educating patient, family, caregivers, or community providers about post-acute care plans.

• §482.43(c)(4): The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

The discharge plan should be initiated as soon as possible after admission. As changes in the patient's condition and needs occur, the discharge plan must be reassessed and updated to address those changes.

• §482.43(c)(5): As needed, the patient and family members or interested persons must be counseled to prepare them for post-acute care.

Records should show that the patient and/or family and/or caregiver were provided information and instructions in preparation for post-acute care and kept informed of the progress. It is important that the patient and caregivers know, and as appropriate, can demonstrate or verbalize the care needed by the patient.

Use of family caregivers in providing post-hospital care should occur when the family is both willing and able to do so. It is appropriate to use community resources with or without family support whenever necessary.

• §482.43(c)(6): The hospital must include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

The Social Security Act (SSA) at §1861(ee) requires Medicare participating hospitals, as part of their discharge planning evaluations to:

- Share with each patient, as appropriate, a list of Medicare-certified HHAs that serve the geographic area in which the patient resides and that request inclusion on the list. The SSA prohibits hospitals from limiting or steering patients to any particular HHA and must identify those HHAs to whom the patient is referred, in which the hospital has a disclosable financial interest, or which has such an interest in the hospital.

- Include an evaluation of the patient's likely need for hospice care and post-hospital extended care services, and to provide a list of the available Medicare-certified hospices and SNFs that serve the geographic area requested by the patient. The discharge plan should not specify or limit qualified hospice or SNFs and must identify those entities to whom the patient is referred in which the hospital has a disclosable financial interest, or which has such an interest in the hospital.

- Develop and maintain its own list of hospices, HHAs, or SNFs; or in the case of SNF, simply print a list from the Nursing Home Compare site at http://www.medicare.gov/ based on the geographic area that the patient requests.

• §482.43(d): Transfer or Referral. The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services as needed for follow-up or ancillary care.

The hospital must ensure that patients receive proper post-hospital care within the constraints of a hospital's authority under state law and within the limits of a patient's right to refuse discharge-planning services. If a patient exercises the right to refuse discharge planning or to comply with a discharge plan, documentation of the refusal is recommended.

"Medical information" may be released only to authorized individuals according to provision §482.24(b)(3). Examples of necessary information include functional capacity of the patient, requirements for healthcare services procedures, discharge summary, and referral forms. "Appropriate facilities" refers to facilities that can meet the patient's assessed needs on a post-discharge basis, and that comply with federal and state health and safety standards.

• §483.43(e): The hospital must reassess its discharge planning process on an ongoing basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

The hospital's discharge planning process must be integrated into its quality assurance and performance improvement program. The hospital should have a mechanism in place for ongoing reassessment of its discharge planning process. Although specific parameters or measures that would be included in a reassessment are not required, the hospital should assure the following factors in the reassessment process:

- time-effectiveness of the criteria to identify patients needing discharge plans;

- the quality and timeliness for discharge planning evaluations and discharge plans;

- the hospital discharge personnel maintain complete and accurate information to advise patients and their representatives of appropriate options;

- the hospital has a coordinated discharge planning process that integrates discharge planning with other functional departments, including the quality assurance and utilization review activities of the institution and involves various disciplines.

Summary

This month, we completed our discussion of compliance with the Conditions of Participation for discharge planning. We will complete our compliance series next time with a review of other areas of compliance required by case managers and case management departments. ■

(continued from page 50)
associate director at Berkeley Research Group.

Wagner suggests ending the variation in supplies and apparatuses as well, a move that will reduce costs and create consistency. "If hospitals take the variability out of the system, they generally end up with lower costs, improved quality, and consistent clinical outcomes," he says.

Create a dashboard, hand out report cards to all clinicians, and review data to identify opportunities, Marshall says.

After the program begins, committees specific to each category of diagnoses the hospital has chosen should monitor progress, track quality and outcomes, and make improvements with the goal of reducing costs and improving quality of care, Steele recommends.

"The goal is to lower the length of stay and cost of care while maintaining good outcomes. The analysis and changes should be in real time," he says.

For instance, when patients are readmitted, the committees should immediately analyze the stay and the discharge plan to determine the cause and how the readmission could have been avoided.

As part of the bundled payment initiative, case managers should make sure every clinician is adhering to the clinical path. Track and trend physician practices and work with your physician advisor to educate the outliers, he adds.

Once the care processes are in place and physicians are complying with the order sets, case managers should make sure all physicians are documenting correctly and ordering services that are appropriate for an inpatient stay, says **Brian Pisarsky**, RN, MHA, ACM, director at KPMG Healthcare Solutions.

"Case managers should discuss variations with the individual physician as well as with the department's physician advisor. There may be a good reason for the variation," Pisarsky says. ■

Don't Do the 'Same Old Thing' When It Comes to Bundled Payments

Financial risk makes collaboration, better oversight essential

Case managers can't just keep doing the same old thing when bundled payments arrangements begin. Because the hospital is taking a financial risk by participating, case managers must ensure patients receive everything they need in a timely manner and move through the continuum quickly and safely.

One of the biggest obstacles to cost-effective care is the disconnect between the various roles involved in caring for patients, says **Donna Hopkins**, MS, RN, CMAC, a case management consultant based in Boerne, TX.

Hospitals have added personnel across the continuum to ensure compliance with new CMS rules, Hopkins points out. "As a result, the leaders of one department don't always know what the staff in another department is doing, and they may duplicate their efforts or omit a crucial task because they think staff in the other department is doing it," she adds.

She relates a personal experience when the case manager didn't know the patient navigator. Both of them were arranging follow-up appointments. "They should be working together to coordinate care, but this is what can happen when there are different senior leaders overseeing care coordination and each has a different agenda," she says.

When there are multiple roles responsible for care coordination and follow-up, they should be supervised by one leader, Hopkins advises. "This helps ensure that the various staff members work in a coordinated effort," she adds. She suggests that one central role monitor care over the entire continuum from the doctor's office through the end of post-acute care.

Hopkins and other consultants offer more tips for surviving under bundled payments:

"If the leaders of one department, provider, or service don't know what the other is doing, they may duplicate or omit services," she says. "We have learned that having one electronic medical record is not the solution. There needs to be a centralized care coordination role by service line to scrutinize the patient care over the entire continuum, from the doctor's office through post-acute care," she says.

The bundled payments program creates an opportunity for physicians in the community, other post-acute

providers, and hospitals to work together to deliver high-quality care, says **John Wagner**, associate director at Berkeley Research Group.

With bundled payments covering the episode of care from admission to 90 days after discharge, the at-risk provider — in most cases, the hospital — must provide oversight after discharge, says **Ken Steele**, principal with ECG Management Consultants.

He recommends that case managers collaborate with their counterparts at patients' primary care providers and the offices of whatever specialists they are seeing after discharge to make sure everyone is on the same page. Work with the case managers at skilled nursing facilities, home health agencies, and other post-acute providers, he adds.

Connect patients with the care managers that will coordinate their care after discharge, such as those at an insurance company, physician practice, accountable care organization, or a community organization. "Make sure everyone who will touch the patient — either in person or virtually — after discharge knows the plan of care and communicates across the continuum," says **Brian Pisarsky**, RN, MHA, ACM, director at KPMG Healthcare Solutions.

"Remember that the cost of post-acute care is part of the bundle, and make sure you guide patients in their choice of the most appropriate post-acute providers," Pisarsky adds.

You still have to give patients a choice, but you can mention the providers that have produced good outcomes, he says.

Case managers should give their recommendations for post-acute care, but still give patients a choice, Steele says. "For some patients, it's their first experience with post-acute care and they may not be able to differentiate between providers. Case managers can guide them in the decision-making process," Steele says.

Meet patients with planned admissions before they are admitted to assess their support systems and living situations and to give patients an idea of the normal course of care when they're in the hospital, their expected length of stay, and what they'll need to do after discharge, Pisarsky says. Take the opportunity to help patients choose their post-acute provider, if needed, before they come into the hospital.

"There are a lot of things that can be done ahead of time during the preadmission visit," Pisarsky says. For instance, joint replacement patients can get the prescription for a walker during preadmission testing, he adds. Meet with the family before a planned surgery and ensure they understand the pathway for the patient care process. Explain the roles of the case manager, staff nurse, physician, and any other clinician who will see the patient.

CMS is going to base its price target for the bundled payments project partly on risk-adjusted data, says **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services, a Shawnee, OK-based healthcare consulting firm. Hospitals must make sure Hierarchical Condition Category diagnoses are adequately documented so they can be correctly coded, she adds.

"Even though the diagnoses don't impact the DRG payment, they do impact the calculation of severity of illness and that plays a big role in determining whether the hospital achieves success or not. Failure to get credit for the complexity of their patients can sink a hospital's bundled payment boat," she adds. ■

AHA Requests Delay of Application Deadline for Bundled Payments Program

The American Hospital Association (AHA) has asked CMS to delay the March 12 deadline for hospitals to apply for the Bundled Payments for Care Improvement Advanced program and to furnish more detailed information on how the program would work.

In a letter to CMS Administrator Seema Verma, AHA Executive Vice President **Thomas P. Nickels** wrote that while the AHA agrees with the principles underlying the program and believes it could help transform care delivery, it is concerned that CMS has not provided sufficient details about the model, which makes it difficult for hospitals and clinicians to make informed decisions about participating in the voluntary program.

He recommended that CMS delay the deadline for applications from March 12 to April 16 and provide a "complete package of detailed programmatic information by March 1."

The new program includes 29 inpatient clinical episodes and three outpatient clinical episodes. The episode of care begins at the start of an inpatient or the start of an outpatient procedure and ends 90 days later. Participants will receive regular Medicare fee-for-service payments for care.

The program will evaluate providers' performance retrospectively every six months, comparing the total cost of care for the clinical episode to a target price that will be provided before the performance period begins. Payment for participants also is tied to performance on quality measures. CMS will use the performance and quality data to determine whether the provider will receive a bonus or is required to repay CMS for part of the reimbursement.

"Our members support the healthcare system moving toward the provision of more accountable, coordinated care and are redesigning delivery systems to increase value and better serve patients," Nickels wrote.

In the eight-page letter, Nickels requested that CMS make changes in the program he says would facilitate hospital participation in the program and success in providing quality care to patients and saving costs. He asked the agency to clarify which quality measures would be applied to which clinical episodes and voiced concerns about the hospitalwide readmission measure CMS plans to use as a quality measure.

Among other suggestions was a request that CMS add a sociodemographic adjustment to the readmission, complication, and mortality measure, adding that research has demonstrated that community factors beyond the hospital's control affect patient outcomes after discharge.

"A sociodemographic adjustment using a well-established proxy for community factors — such as income or dual eligibility for Medicare and Medicaid — would help level the playing field among providers caring for large numbers of disadvantaged patients and those who do not do so," Nickels wrote. ■

EDs Confront Surge in Hospitalizations and Deaths From Flu-related Complications

States continue to see spikes in volume and worry that the peak is yet to come

With flu widespread in every state except Hawaii, frontline providers have been busy this year trying to stay ahead of what is shaping up to be a robust flu season. To cope with spikes in volume, hospitals in some regions are canceling elective surgeries, restricting visitors, opening new treatment areas, and scrambling to stay ahead of staff and supply shortages. Some are diverting ambulances elsewhere to manage capacity.

Indeed, the flu arrived early, putting many hospitals on their heels by the end of December, and with the number of flu cases way up, flu-related complications have spiked, too. Hospitals in Colorado reported nearly triple the usual number of flu-related hospitalizations in late December. Similar reports have emerged from other states.

The Chicago Fire Department added five ambulances to handle the flu-related surge in the first week of January, and hospitals there have been reporting much higher volumes than what they experienced last year.

Of particular concern is the number of flu-related deaths confirmed in children. By mid-February, the CDC noted that 84 children had died from flu-related complications.

Push Flu Vaccinations

Most cases of confirmed flu thus far have involved the H3N2 strain, a cousin to the swine strain that caused a big outbreak in 2009, explains **Bettina Fries**, MD, FIDSA, chief of the division of infectious diseases at Stony Brook Medicine in Stony Brook, NY, a health system that includes three hospitals and several other health centers on Long Island. However, she notes there is evidence from Australia that there could be some drift in the strains that are circulating. "These strains all have so-called segmented genomes. That means their genomes are made up of eight separate pieces of DNA, and they can basically mix and change," Fries notes. "What we see a lot of times is that the strains change over the course of the flu season, and that can sometimes make them different at the end of the flu season."

In mid-January, the number of

flu cases still was on the rise in most regions of the country, according to the CDC. That is in line with what Fries is observing in her own setting.

"Right now, we are having a lot more admissions related to flu, and whether this is the result of a less efficacious vaccine or whether this is just a more potent strain, time will tell," she says. "However, even if the vaccine is not as efficacious, we still want to very aggressively pursue vaccinating as many people as possible because flu vaccines in general are usually only between 30% and 60% efficacious, but there is still a huge benefit if you decrease the number of patients that present with flu and the time in which they are infected with the flu virus."

Fries urges providers to be especially concerned with patients most at risk for flu complications.

"The patients with the highest mortality are elderly patients over the age of 65 and patients that are immune compromised," she says. These include patients on chemotherapy or other drugs that suppress the immune system. Also of concern are patients who are obese, very young children, Native Americans and other ethnic groups known to be at increased risk for flu complications, and patients with underlying respiratory problems such as asthma.

The challenge for frontline providers is staying ahead of spikes in flu-related volume because flu spreads very quickly, Fries observes. "The big problem with flu from a public health point of view is that once the genie is out of the [bottle], it is extremely difficult to contain because patients are infectious about 24 hours before they present [with symptoms]," she explains. "That is why in 2009, when we had this big pandemic, [the flu] popped up in a few places in New York and then all of a sudden everybody had it."

Add Treatment Areas

Clinicians at Stony Brook University Hospital are aggressively screening patients with upper respiratory symptoms for viral infections so that they stay on top of their own numbers.

"We are not only seeing flu. We are seeing other respiratory infections as well," Fries adds.

Sharp Grossmont Hospital in La Mesa, CA, began seeing a steady trickle of patients with the flu before Christmas, but that quickly turned into a deluge immediately after the holiday.

"We came back on [Dec.] 26 to an ED that was inundated with patients with flu symptoms," explains **Marguerite Paradis**, BSN, RN, MHA, the director of emergency services and critical care at the hospital. "We usually don't have patients waiting in the waiting room in the morning because we usually can get everyone seen. When we came in on the 26, there were 50 patients waiting in the waiting room, which we had not seen in a very long time."

There were even more patients in the waiting room the following morning, and that opened everyone's eyes to the challenge that lay ahead. "We knew we were not going to decompress. We couldn't even decompress from the day before," Paradis recalls. "Our average daily visits are around 280 or 290, and that week, starting on the 26, we went up to about 360 visits."

To manage the surge, ED personnel fully leveraged a rapid treatment center that had been implemented in the department to take care of lower acuity patients.

"It became basically our flu clinic at the peak of the flu season for patients who were not severely ill from the flu," explains **Julie Phillips**, MD, FACEP, medical director of the ED at Sharp Grossmont. "We had been seeing 30% to 38% of patients in the ED in that area, but during the peak of the flu we probably saw about 50% of patients there, and most of these patients didn't require anything other than rapid treatment and diagnosis."

Additionally, on Dec. 27, the ED constructed a surge tent in which staff assembled a second rapid treatment area.

"We were worried that we would not be able to assess all these patients in a timely manner without an extra treatment space," Phillips observes. "We were seeing things other than flu there, but it went up and we needed the extra space because of the volume of flu patients we were seeing. It became a second minor treatment area."

During peak times, the ED was seeing more than 20 patient arrivals per hour, Paradis says.

"Probably at least one-third of our patients were impacted by the flu," she says, noting they were not all low-acuity patients. "We saw a lot of very sick patients affected by the flu, and of course many patients were admitted to the hospital, so we were holding two or three times the [usual] number of admitted patients waiting for beds in the ED."

Stay Alert to Complications

Many of the more severe cases involved elderly patients who were just too sick to be cared for at home.

"What happens when the flu becomes quite severe is patients may become very short of breath and they can get secondary pneumonia," Phillips notes. "Some of them may need a ventilator because they can't breathe anymore. Some of them may need oxygen because they are just not getting enough into the lungs."

A second problem that can occur is patients will become dehydrated and their blood pressure will decrease, leading to a cascade of other problems.

"Once you have low blood pressure, that is when things really start to get out of control really quickly, and that is when patients can become septic," Phillips explains.

While it is not clear yet to Phillips if this year's flu is actually more severe than in a typical year, she knows that it seems worse because so many more patients are getting sick.

"I am not sure if each patient is much sicker than they would be with other strains. It is just that the volume has added more sick patients to the ED and more sick patients in the ICU than what we typically see," she says.

However, there are promising signs that the peak of this year's flu season, at least for Sharp Grossmont, has passed. By mid-January, flu volumes were roughly one-third of what they had been earlier in the month, although clinicians certainly expect to see flu patients for many weeks to come.

"We still have patients coming in with the flu continually. Some will be very, very sick, and some will be more minor," Phillips says.

While the flu surge may be over for Sharp Grossmont, Phillips believes that the array of strategies the hospital used to manage flu-related capacity issues can work for other hospitals, too. In particular, her advice to clinicians is to take appropriate steps to protect themselves.

"Providers need to know that this is a pretty nasty strain of flu, and they need to stay healthy so that they can continue to help take care of the community," she explains. "You need to wear a mask."

Also, consider added steps to protect patients. For instance, Sharp Grossmont has been offering hand sanitizer and a mask to everyone coming into the ED, Paradis notes.

"When you have these overwhelming volumes, patients are in close proximity to each other, and you have flu patients combined with non-flu patients," she says. "I think trying to keep these groups segregated is helpful."

Working with the hospital communications team to keep the community well-informed about flu outbreaks can help manage both volume and patient expectations. For instance, Sharp Grossmont used newsletters, social media, and interviews with local news outlets to keep area residents informed about all aspects of the outbreak, including what a typical flu course involves, who is most at risk, when a visit to the ED is necessary, prevention tips, and what to expect when patients do present to the ED. Further, the hospital translated its flu-related messaging into multiple languages for diverse communities.

"We also had to educate about hospital visitors," Phillips explains. "Children aged 12 and under were totally restricted. Also, if anyone had flu symptoms, they were not permitted to visit a patient in the hospital."

If an ED is going to be busy with lower-acuity patients, opening additional treatment areas can work well in managing the volume, Paradis advises. She notes that the strategy worked well for Sharp Grossmont, first when staff set up a second rapid treatment area in the surge tent, and then later when they created a second treatment area within the main ED.

"We just replicated our accelerated care process," she adds. ■

COMING IN FUTURE MONTHS

- Make technology work for you
- The pros and cons of offsite utilization review
- What is CMS up to now?
- Focus on case managers in ED

HOSPITAL
CASE MANAGEMENT

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CE QUESTIONS

1. **When does the Bundled Payments for Care Improvement Advanced program begin?**

   a. July 1
   b. Oct. 1
   c. Jan. 1, 2019
   d. To be announced

2. **According to Beverly Cunningham, RN, MS, ACM, when the new bundled program starts, case managers should analyze all charges and costs and compare the cost of care to the target price set by the Centers for Medicare & Medicaid Services.**

   a. True
   b. False

3. **According to Donna Hopkins, MS, RN, CMAC, what is one of the biggest obstacles to cost-effective care?**

   a. Providers who refuse to follow the protocol
   b. Patients who don't follow their treatment plan
   c. Glitches that result in patients staying after they no longer meet inpatient criteria
   d. The disconnect between the various roles involved in caring for patients

4. **The American Hospital Association (AHA) has asked the Centers for Medicare & Medicaid Services to delay the deadline for hospitals to apply for the Bundled Payments for Care Improvement Advanced program. What deadlines does the AHA suggest?**

   a. Oct. 1
   b. April 16
   c. March 12
   d. May 30

CE OBJECTIVES

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

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