HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

RELIAS
Formerly AHC Media

JUNE 2018 Vol. 26, No. 6; p. 73-88

Weighing the Pros and Cons of Offsite Utilization Review

With utilization review (UR) requirements and guidelines becoming more and more onerous, many larger organizations are creating a centralized UR process. That means that when a new patient is registered in the ED, an offsite case manager can be alerted to the new patient, see all documentation necessary to determine whether the medical record supports the patient's status, and work with the physician on the phone or the ED case manager while the decision is being made to admit or begin observation services.

Because the offsite reviewers are working from a remote location, they do not need to see patients for this step in the utilization process.

"What we're seeing are a number of organizations centralizing and combining their utilization review. Many are in hospital systems that are continuing to combine and consolidate. It is occurring at large healthcare systems, and I know of several of them," says **Brian Pisarsky**, RN, MHA, ACM, a director at KPMG Healthcare Solutions.

> "WE HAVE NEVER SEEN A MODEL WHERE THERE HASN'T BEEN A SILO MENTALITY AND A DECREASE IN THE SENSE OF URGENCY WHEN A SEPARATE UR FUNCTION IS INCORPORATED."

Pisarsky speaks of a 13-hospital system in the Midwest that implemented offsite UR after experiencing a significant increase in denials and multiple issues with payers.

"In order to solve this, instead of having 13 different processes, now they have one," he says.

While this sounds like an effective solution that comes with obvious

Financial Disclosure: Author **Elaine Christie**, Author **Mary Booth Thomas**, Editor **Jill Drachenberg**, Editor **Jesse Saffron**, Editorial Group Manager **Terrey L. Hatcher,** and Nurse Planner **Toni Cesta**, PhD, RN, FAAN, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

HOSPITAL CASE MANAGEMENT

Hospital Case Management™,
ISSN 1087-0652, is published monthly by
AHC Media, LLC, a Relias Learning company
111 Corning Road, Suite 250
Cary, NC 27518
Periodicals Postage Paid at Cary, NC, and at additional mailing offices.

POSTMASTER: Send address changes to:
Hospital Case Management
111 Corning Road, Suite 250
Cary, NC 27518

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

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

Outside U.S., add $30 per year, total prepaid in U.S. funds.

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GST Registration Number: R128870672.

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This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers. The course is approved for 1.5 CE contact hour(s).

The target audience for *Hospital Case Management*™ is hospital-based case managers. This activity is valid 36 months from the date of publication.

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benefits, it's also a system that requires streamlined processes, transparent policies, and an eye toward minimizing any potential risks.

On the one hand, taking the UR functions away from the unit-based case managers frees them up to spend more time at the bedside. On the other hand, it could lead to breakdowns in communication, among other issues, says **Beverly Cunningham**, MS, RN, ACM, partner and consultant at Case Management Concepts.

"We have never seen a model where there hasn't been a silo mentality and a decrease in the sense of urgency when a separate UR function is incorporated," Cunningham says. "The vast majority of these are off site, and this is difficult for communication with staff, physician advisors, the ED, and patients."

Benefits to Offsite Utilization Review

The following are a few pros to consider, with a glimpse into how others are implementing such systems in their own organizations.

Pro 1: Maintaining a common process.

If two hospital systems come together and there are now six hospitals, that means six different UR departments must keep up with CMS rules and all rules for every payer. But if they centralize all utilization review, they have a common electronic medical record to review every single patient.

"Now you're bringing that into one source and every patient is being reviewed as they need to be. It really brings those folks together who know the rules. It becomes a common process. That's a big move," says Pisarsky.

Pro 2: Understanding denials.

A centralized, consistent process can better use resources, can ensure a better understanding of what is denied up front, and streamline which payers are giving hospitals the biggest issue.

"In my opinion, if utilization review is a centralized process, then the UR specialist should be the first person who is looking ahead to see what's needed to get approval, and they should contact the physician to get what is needed to support the level of care," says **Vivian Campagna**, MSN, RN-BC, CCM,

EXECUTIVE SUMMARY

Some larger organizations are creating a centralized utilization review (UR) process. Taking the UR functions away from the unit-based case managers can result in more time at the bedside, but there are factors to weigh before investing in a centralized process.

- Develop a solid, transparent communication plan for the whole team to minimize the potential for duplicate duties and extra work.
- Consider how electronic methods could make this approach possible — but don't forget to include the information security department to protect patient information.
- Continue to meet regularly with stakeholders to gauge what fell through cracks, the number of denials, and what can be improved.

chief industry relations officer for the Commission for Case Manager Certification.

Then, the UR specialist should contact the case manager to inform him or her about a potential denial because the patient isn't meeting criteria for admission, she cautions.

"At that time, the case manager can contact the physician to discuss the patient's acuity or whether they should be moved to another level of care. That's how it should happen — before the denial, not afterward," says Campagna.

Pro 3: Reducing readmission rates

When UR is separate from case management, it allows case managers the time and opportunity to perform the roles and responsibilities they do best, like care coordination. If hospitals task case managers with daily insurance utilization reviews, it may preclude them from meeting with patients, working with physicians when they come in, participating in team huddles, coordinating care, and ensuring the patient has the resources, information, and education to move toward goals and reasonably advance toward discharge.

That's the work that will help avoid a readmission, according to Campagna.

"I think it's good to have a clinician — for example, a nurse — who becomes a utilization review specialist — a person who knows the nuances of the reimbursement system and specializes in it — rather than the case manager doing utilization review. As a specialist, they are familiar with the various insurance and Medicare contracts and carveouts, as well as what's required to justify the patient's admission and hospital stay," she says.

A specialist will provide the pertinent information to document the acuity of the patient more efficiently. When case managers perform UR, it typically is an administrative task in addition to case management duties.

Campagna points out that because it's not their core work, there is a tendency to offer too much information from the medical record, which can open opportunity for a denial.

"It's in the hospital's best interest to place the individual who best understands the CMS and managed care guidelines and the individual contracts involved so they can structure the information needed in the most appropriate way," she says.

Things to Consider With Offsite UR

The following are a few possible cons of offsite UR, and ways an organization can work to prevent these problems.

Con 1: Lack of communication.

The offsite utilization management staff rely on transparency and continually updated data while communicating from an entirely different location than physicians, case managers, social workers, clinical leadership, and other staff.

Although offsite UR teams can email daily reports to the hospital-based case managers, there should be effective communication plans in place from the start, according to Pisarsky. Take into account that if the organization views the role of utilization management as an isolated set of tasks, the role could become separated from the other roles of the case manager.

After all, utilization review should drive the discharge planning across the continuum of care.

"In other words, if I'm the case manager on the floor, I know the patient is moving along and moving away from still needing to be in the hospital. One possible problem with offsite UR is lack of communication. For example, when you're depending on the case manager on unit to be informed by UR staff that a denial has occurred, or this patient is running out of criteria to be here," he says.

Remember that investing in a centralized UR process without a great communication plan between all stakeholders is essentially creating duplicate duties, potential for poor communication, and extra work.

If organizations are looking to implement this and have distributed team members, they should bring all stakeholders in to ensure they're mapping this process every time and for every patient. For example, when criteria changes, are there monthly in-office trainings and continual interrater peer reviews to verify accurate criteria and policy/procedure application?

"As organizations continue to implement processes for centralized utilization review, there are many ways they improve the process. Initially their key stakeholders should be meeting weekly, then move to monthly meetings, but I don't see where this key stakeholder team will ever go away," says Pisarsky.

"Stakeholders need to make sure they're reviewing during these meetings current opportunities for improvement and what fell through cracks," he adds. "They must be reviewing denials, and they must always ask 'What didn't we do appropriately and what can we do better next time?' to find remedies."

Another dynamic is figuring out — and effectively communicating — staffing ratios for centralized vs. decentralized processes. One example is having 150 case managers across a hospital system performing UR that now wants to centralize, and working out who works on holidays and weekends.

But it's impossible to define a specific staffing ratio, according to Campagna, because it depends on the type of patient on the unit and even the type of patient the hospital sees. For example, a safety net hospital may see more patients who require more services from a case manager, while a hospital that serves more managed care patients typically requires case management to interact with fewer complex patients, she says.

Because it would be tough to determine how long each clinical review will take, it would become a matter of performing the process for some time, meeting regularly for review, and then collecting information to create benchmarks, Campagna adds.

A good first step in this process is to form a committee and meet at least four to six weeks before making this change. Make sure to map all the necessary processes. Pisarsky offers these points to consider:

- talk about best practices;
- work out logistics (e.g., "Do I take two folks from every campus, or will UR staff work from home?");
- determine metrics/ratios;
- implement logistics (e.g., Where will staff work? What are the roles of the different individuals? How do we notify if patient is getting denial? How do we notify doctors?);
- implement communications methods (e.g., What new software, tools, or systems would need to be implemented?)

Con 2: Who's contacting the doctor?

With an offsite utilization review in place, who is talking to the physician? Does the remote UR staff call the onsite case manager to talk to physician, or do they call the physician directly?

Consider a scenario where the UR team receives a denial, necessitating a peer-to-peer discussion between the doctors. Because the UR staff knows what information is needed to demonstrate acuity, they should call the physician directly and ask for appropriate documentation, according to Campagna.

"THAT'S WHERE I SEE A MAJOR MISSTEP WITH UR BEING DONE REMOTELY — WHO TALKS TO THE DOCTOR AND THE PATIENT?"

Also critical is developing policies and procedures for all criteria, including notifying the insurance company, denials, and the processes for a referral to a physician assistant.

"When the patient is looking closer to meeting discharge criteria, what would need to happen in talking to the physician is he or she may say 'I think this patient needs one more day and here's why.' So we'd want the physician with the insurance company to have a peer-to-peer conversation with the physician who is seeing the patient," Pisarsky says.

He points out that the case manager on the floor knows the physician much better than a UR person who is working remotely.

"That's where I see a major misstep with UR being done remotely — who talks to the doctor and the patient?" he says.

One way to avoid this pitfall is to consider the use of video meetings or discussions with the offsite UR team.

"There are organizations that have computers on wheels and have the patient talk to physicians over that system; there are a multitude of electronic methods that make this approach possible," he says.

Con 3: Data security policies and cybersecurity threats.

Remote electronic safety is another potential concern. Case managers who work from a home office with online access to patients' sensitive medical records are tasked with many responsibilities, including working with physicians to determine the patient's status and level of care on admission, and determining whether the patient meets admission criteria. But what about protecting the privacy of patients' records?

"One of the imperatives is have your information security as part of the key stakeholder team. There are organizations in the western U.S. where every single one of their reviews is handled remotely; they just need a laptop or PC at home to connect in and parameters around reviews, such as how many per day, and a telephonic or secure fax or email notification process," says Pisarsky.

The very real risks of cybersecurity attacks and data breaches should be understood among all team members in a distributed, offsite UR team. Include the information security department to figure out which security

measures need to be included and make sure everyone on the team is following the same protocols.

Evolution in the Role of Case Manager

This division of labor between the centralized UR specialist and the case manager also could be signaling something of an evolution in the role of the case manager.

Utilization review used to send the information to the insurance company and then wait for them to call back. Now, it is a 16- to 24-hour-a-day process at many institutions.

"I think hospital administration needs to recognize the fact that there are many things that add value and better merit the case manager's attention other than utilization review. Especially in today's EHR environment, UR is a function that can be easily done outside the scope of the case manager's job description," says Campagna.

"Professional case managers should be focused on care coordination throughout the acute episode of care; managing the patient with the team to do the assessment, creating the plan of care, overseeing its timely and efficient implementation and, when it's time, moving the patient to the appropriate level of care with the best education and information possible to prevent an avoidable readmission," she adds.

From a leadership standpoint, she adds that the role and the value of the case manager could get diluted when tasks such as UR are added to the workload. Because of time and workload constraints, this can make them less effective to do the important tasks of case management. ■

Is the Dyad or Triad Model Best?

Five strategies across the continuum of care

What's the best structure for case management models — dyad or triad? While everyone wants the magic answer, there's no one-size-fits-all approach.

As hospital case management models continue to evolve, some hospitals continue to use the blended, or dyad, model, where case managers perform all functions.

Proponents of a triad case management model say that it's more efficient for a case manager to handle care coordination and discharge planning — if they have a small enough caseload.

Beverly Cunningham, MS, RN, ACM, a partner and consultant with Case Management Concepts, says the ideal contemporary model is a triad model, with the functions of utilization management, discharge planning, and care coordination.

"The ideal case management process is not to silo case management functions. This is often found in the dyad model," Cunningham says. "There are so many things to consider when selecting the best model. Understanding why hospitals transition from a triad model to a dyad model is incredibly important. There might be a need, but I would think this is rare, for a dyad model in the situation of very challenging payers."

However, she notes that this often can be eliminated by having a very strong appeals process in the case management department that works with staff, physicians, payer contracting, and payer relations.

The biggest thing to take into account is the communication flow throughout the hospital.

"That really is where the dyad model — where UM [utilization management] is often separate — can set the scene for siloed communication. It also sets the scene to diminish a sense of urgency. Effective utilization management is an urgent process; it's a priority that must be done," says Cunningham.

For example, what is the case manager at the bedside witnessing overall? What is he or she hearing from team members (e.g., a physical therapist or a dietician) and from the physician?

"If you're an RN case manager on the floor, you just talk to the doctor. When you silo that role out, you lose that opportunity for complete and timely communication. That's a challenge," notes Cunningham.

Five Strategies to Implement

The following are five key points to consider when choosing a model:

1. Understand your payer needs.

With either the dyad or triad model, there should be strong understanding of payer needs and requirements, physician advisor roles, etc.

For example, larger urban areas typically have more payers, more commercial plans, and more Medicare/Medicaid plans.

Take a step back to see all the driving forces:

- Is there an accountable care organization?
- Is there a patient-centered medical home?
- Does the continuum include bundled payment patients?
- What providers in the continuum are owned by the hospital — such as home health, hospice, acute rehab, inpatient psych, outpatient psych, physician offices, and skilled nursing facility?

2. Know your processes.

Use a flowchart to help decide what's best at your hospital, particularly when it comes to ensuring seamless communication for everyone on the medical team.

"If there's a really good electronic case management program, you have to educate the case manager on the floor about their responsibility. Do they, or can they, watch their computer to see what's going on?" asks Cunningham.

In the case of remote case managers, figure out who's going to call the doctor and document the process. But if it's the onsite nurse case manager who needs to call the doctor, then document that process, too.

Another idea is to perform a pilot test and see which works best. The results could be surprising and show that what worked on one floor (e.g., medical/surgical) didn't quite work on another.

3. Educate everyone to the ideal processes.

Not many case management departments have an educator, but some do.

"That's a key role in a case management department," says Cunningham. "They can maybe do a small class and then individually mentor staff. Maybe you have team leads or managers or people who really understand the process and can help staff. Small group education and mentoring on the floor is important."

But if teams include offsite utilization review, consider webinars and similar video conferencing tools for ongoing education that would appeal to everyone, regardless of location.

Whether onsite or online, remember to look at the processes involved in ongoing education and share the results. Communication is key in ongoing education.

4. Evaluate the outcomes.

Identify a few key outcomes that may affect denials.

"Often, the initial switch to offsite utilization review was due to too many denials, so identify areas that need improvement and what can be fixed," says Cunningham.

But don't collect so much data that people don't know what to do, she warns.

"Pick just a few things to evaluate on a week-by-week basis, such as denials or feedback from physicians as a process outcome. After 30, 60, and 90 days, analyze the results on denials, and make sure to share that information," she says.

5. Improve on any gaps.

Finally, remember to mind the gap — use the newly collected data to fix any issues.

If physicians are complaining about too many calls, what can be done about that? For example, do the doctors prefer texts to a phone call?

Another example is the remote utilization review (UR) nurse who needs to contact a physician or nurse case manager because the patient isn't meeting medical necessity.

"A sample goal is the UR nurse would have a response within an hour. That's one of your process measures — do they have a response within an hour from the case manager or physician?" Cunningham asks. "The data may show that it took more than an hour. If you're constantly having delays, then that interferes with the sense of urgency."

If the delays are only with one unit or only with one physician, then delve into the data to identify gaps and strategies for total process improvement.

"Let's say you have five gaps — pick the most important or pick the one that's the most low-hanging fruit and take care of that, and then move on to the next one," she adds. ■

EXECUTIVE SUMMARY

Although the ideal contemporary model uses a triad model, there's simply not a perfect method for every hospital. That's why case management leaders should look at what makes the most sense — dyad or triad — and analyze how the different approaches could affect denials.

- Focus on the communication flow throughout the hospital and find ways to maintain the sense of urgency that utilization management demands.
- Evaluate three to five key outcomes that affect denials on a regular basis. Analyze how the results affect denials, and make sure to share that information.
- Pilot test different models, perhaps focusing on different areas or floors, to see which approach works best.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

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

By **Toni Cesta**, PhD, RN, FAAN

Introduction

In the last three issues of *Case Management Insider*, we covered a variety of case management compliance issues related to utilization review and discharge planning. In this, our fourth part in the series, we will discuss additional compliance issues important to you in your case manager role.

Compliance: A Shared Responsibility

Although we are discussing compliance from the case management point of view, compliance is a shared responsibility among all members of the interdisciplinary care team. Virtually every member has some piece of the compliance pie. In today's healthcare environment, compliance starts at the hospital's entry points and continues until the patient is safely transferred to another level of care or is discharged to his or her home. While the majority of your patients probably will gain entry to your hospital via the ED, others may be direct or urgent admissions, transfers, or even observation patients. Let's start our discussion this month with a review of the compliance issues related to observation status.

IN TODAY'S HEALTHCARE ENVIRONMENT, COMPLIANCE STARTS AT THE HOSPITAL'S ENTRY POINTS AND CONTINUES UNTIL THE PATIENT IS SAFELY TRANSFERRED OR DISCHARGED.

Compliance and Observation Status

When discussing observation status, we should begin with a review of the Two-Midnight Rule and how your compliance with the rule will have a negative impact on reimbursement and potential audits if not managed properly. Observation is defined as follows by the Centers for Medicare & Medicaid Services (CMS):

"Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital." (Internet-Only Manual [IOM], Publication 100-04, Chapter 4, Section 290).

This simply means that observation status can be used in the event that the physician needs more time to evaluate whether a patient can be discharged or needs more time in the acute care setting. While reimbursement for observation typically is less than that for an inpatient stay, the care provided usually is the same.

In reality, these are patients in hospitals who receive medical, physician, and nursing care, as well as tests, medications, overnight lodging, and food, but who nevertheless are called outpatients. The Center for Medicare Advocacy calls this issue "outpatient observation status" because there are no hospital services that are distinctly "observation," and because these outpatients receive care and treatment that are identical to the care and treatment received by inpatients.

The Two-Midnight Rule

This rule was put into effect to provide a framework

for determining when a patient might need observation vs. inpatient admission and contains a variety of compliance touchpoints. These touchpoints have a direct relationship to the role of the case manager, particularly in the ED. When a patient arrives in the ED, the physician will have one of three options: treat and release the patient, admit the patient to the acute care setting, or place the patient in observation status until a decision can be made as to whether the patient should be admitted.

The question answered by the Two-Midnight Rule provides a decision-making process for the physician to follow with the guidance of the case manager. It requires the case manager to review the patient's case using the hospital's standardized criteria and discuss the case with the physician.

If all of these assessments result in an indication that the patient's stay will likely be greater than one midnight, the physician must document this expectation along with the order to admit. The documentation must support the medical necessity and necessary care needed. This process is concurrent and active, and requires close collaboration between the physician and the case manager.

For this reason, and in order to maintain compliance with the Two-Midnight Rule, many hospitals have begun staffing the ED with case managers 24/7.

The following are exceptions to the Two-Midnight Rule:

- death;
- transfer;
- departure against medical advice;
- unforeseen recovery (faster than expected);
- election of hospice care.

The MOON

One of the newer compliance requirements is the Medicare Outpatient Observation Notice, known as the MOON. The MOON is part of the NOTICE Act, which went into effect Aug. 6, 2016. The NOTICE (Notice of Observation Treatment and Implication for Care Eligibility) Act requires that hospitals provide written and oral notice within 36 hours to patients who are in observation or other outpatient status for more than 24 hours.

THE NOTICE MUST EXPLAIN THE REASON THAT THE PATIENT IS AN OUTPATIENT AND DESCRIBE THE IMPLICATIONS OF THAT STATUS BOTH FOR COST-SHARING IN THE HOSPITAL AND FOR SUBSEQUENT ELIGIBILITY FOR COVERAGE IN A SKILLED NURSING FACILITY.

The NOTICE Act is a requirement of acute care hospitals and critical access hospitals. The notice must explain the reason that the patient is an outpatient and describe the implications of that status both for cost-sharing (deductibles and copays) in the hospital and for subsequent eligibility for coverage in a skilled nursing facility. In fact, observation status cannot be used to qualify a patient for admittance to a skilled nursing facility.

The MOON is not required for all outpatients. CMS requires hospitals to give the MOON only to patients entitled to Medicare for whom they are billing Medicare for observation hours. However, patients who do not have Medicare Part B also should receive the MOON, even though their observation status stay or other outpatient stay in the hospital will not be covered by Medicare Part B because they do not have Part B.

As an RN case manager or social worker, your hospital may require that you provide the MOON to your patients. If so, there are several things that you should know. First, your hospital should use a standard form that is written in plain language and made available in all appropriate languages. The form must be signed by the patient or by an individual acting on behalf of the patient in order to acknowledge receipt of the notification. If the patient or their representative refuses to sign, you must sign it if you are the person who presented it.

Below is a sample MOON form that has been provided by CMS for use by hospitals.

Sample MOON Form

Department of Health & Human Services Centers for Medicare & Medicaid Services

OMB Approval No. xxxx-xxxx

Medicare Outpatient Observation Notice (MOON)

Patient Name:

Patient ID:

Physician:

Date:

Time:

On <date> at <time>, you began receiving observation services at <hospital name>. You are a hospital outpatient receiving observation services, also called an observation stay. You are not an inpatient.

Observation services:

• are given to help your doctor decide if you need to be admitted as an inpatient or discharged;

• are given in the ED or another area of the hospital; and

• usually last 48 hours or less.

How being an outpatient affects what you may have to pay: Being a hospital outpatient affects the amount you may have to pay for your time in the hospital and may affect coverage of services after you leave the hospital.

Medicare Part B covers outpatient hospital services, including observation services when they are medically necessary. Generally, if you have Medicare Part B, you may pay:

• a copayment for each individual outpatient hospital service that you receive; and

• 20% of Medicare-approved amount for most doctor services, after the Part B deductible.

Part B copayments may vary by type of service. In most cases, your copayment for a single outpatient hospital service won't be more than your inpatient hospital deductible. However, your total copayment for all outpatient services may be more than the inpatient hospital deductible.

If you're enrolled in a Medicare Advantage plan (like an HMO or PPO) or other Medicare health plan (Part C), your costs and coverage are determined by your plan. Check with your plan about coverage for outpatient observation services.

If you are a Qualified Medicare Beneficiary through your state Medicaid program, you cannot be billed for Part A or Part B deductibles, coinsurances, and copayments.

Your costs for medications: Generally, prescription and over-the-counter drugs, including "self-administered drugs" given to you by the hospital in an outpatient setting (like an emergency department), aren't covered by Part B. "Self-administered drugs" are drugs you'd normally take on your own. For safety reasons, many hospitals don't allow patients to take medications brought from home.

If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs in certain circumstances. You'll likely need to pay out of pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, if inpatient hospital services become necessary for you and the hospital admits you as an inpatient based on a doctor's order, generally Medicare Part A will cover inpatient services. Generally, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital. Medicare Part B covers most of your doctor services when you're an inpatient. You may have to pay 20% of the Medicare-approved amount for doctor services after paying the Part B deductible.

How observation services may affect coverage and payment of your care after you leave the hospital: If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you have a prior qualifying inpatient hospital stay. A qualifying inpatient hospital stay means you've been a hospital inpatient (you're admitted to the hospital as an inpatient after your doctor writes an inpatient admission order) for a medically necessary stay of at least three days in a row (not counting your discharge day) within a short time before you enter a SNF. If you have Medicaid, Medicare Advantage, or other health plan, Medicaid or the plan may have different rules about qualifying for SNF services after you leave the hospital. Check with Medicaid or your plan.

Additional information: If you have any questions about your observation services, please ask the hospital staff member providing this notice or the doctor providing your hospital care. You also can ask to speak with someone from the hospital's utilization or discharge planning department. In addition, you can call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

If you have a complaint about the quality of care you are receiving during your outpatient stay, you may contact the Quality Improvement Organization (QIO) for this hospital. If you have a Medicare Advantage or other health plan, you can make your complaint about quality of care by filing a grievance with your plan. Review your plan materials or contact your plan for information on how to file a grievance. You also can make a complaint about quality of care to the QIO listed above. Please sign and date here to show you received this notice and understand what it says. Signature of Patient of Representative: Date/Time:

The Important Message from Medicare

Hospitals are required to deliver the Important Message from Medicare (IM) to all traditional Medicare beneficiaries and Medicare Advantage plan enrollees who are hospital inpatients. The IM informs inpatients of their hospital discharge appeal rights. Beneficiaries who choose to appeal a discharge decision must receive the Detailed Notice of Discharge (DND) from the hospital or Medicare Advantage plan, if applicable.

In many hospitals, the first IM is given by the admitting or access department when the patient goes through the admissions process. In some rare cases the case management department gives the first IM, but this is not considered best practice.

The second message must be given within two days of the patient's discharge from the hospital. The second message can be given by a clerical support person from the case management department, or even by the admitting or access department depending on your hospital's resources and processes.

In most cases the second message is given by the RN case manager, as he or she is best qualified to explain the IM as well as the patient's rights and the process for appeal. If the patient chooses to appeal the discharge, then the Detailed Notice of Discharge follows. Ultimately, a Hospital-Issued Notice of Non-Coverage (HINN) may also need to be given if any of the criteria for a HINN are met. In no case does the IM replace the HINN.

We will conclude our four-part series on case management compliance with a gap analysis process that you may wish to use in your hospital or in your personal case management practice. Please review the following lists and add or delete as you see necessary.

Sample Case Management Compliance Gap Analysis Form

MEASURE

• Two-Midnight Rule process in place and successful;

HOSPITALS ARE REQUIRED TO DELIVER THE IMPORTANT MESSAGE FROM MEDICARE TO ALL TRADITIONAL MEDICARE BENEFICIARIES AND MEDICARE ADVANTAGE PLAN ENROLLEES WHO ARE HOSPITAL INPATIENTS.

• Two-Midnight Rule audit process in place and reported to UM Committee;

• utilization management committee in place and following Condition of Participation requirements;

• ED case management in place during appropriate hours;

• access case management in place, if appropriate;

• physician advisor process in place and effective;

• all case managers understand role of medical necessity and Two-Midnight Rule expectations;

• all records have orders with correct order to admit;

• effective self denial process in place;

• Important Message delivered appropriately with accurate appeal process in place with QIO;

• HINN delivery process mirrors CMS requirements;

• preparation for proposed discharge planning rules;

• discharge planning process follows Condition of Participation requirements;

• discharge plan re-evaluated at appropriate intervals (for example, after a surgical procedure, discharge plan reassessed);

• policies in place to support compliance rules and regulations;

• RN case manager and social worker documentation support CMS requirements;

• annual IRR of medical necessity criteria RN case managers;

• feedback to department and individual staff from dashboard;

• annual education of staff and physicians;

• collaboration in place for new compliance requirements, such as NOTICE Act and proposed discharge planning rules;

• preparation for NOTICE Act with clear understanding of case management department's role in compliance to act.

Summary

It is critical that each and every case management department be as compliant as they can be. In the past four *CMI* issues, we reviewed the key compliance matters that are of importance to case managers and case management departments. By remaining compliant, you can better ensure that you are working at the top of your license and that your patients receive the very best case management services possible. ■

Text Messages Help Keep Patient Recoveries on Track

Technology expands case management capabilities

A program that sends secure text messages every day to help at-risk patients manage their conditions resulted in a 22% decrease in 30-day readmissions and a 46% improvement in 90-day readmissions for Sharp Rees-Stealy Medical Group patients who received the messages.

The organization developed the text message coaching program in collaboration with a vendor as a way to connect with the growing population of patients who need support and to improve performance on the CMS quality improvement programs, such as the readmission reduction program. Sharp designed the program content and partnered with a vendor to implement it.

"Our case management department budget did not have funds to increase the staff so we could provide one-on-one coaching by telephone to patients who need support. We looked at mobile technology as a way to expand our case management capabilities and to send messages to patients who need support," says **Janet Appel**, RN, MSN, CCM, director of population health for the medical group.

Sharp Rees-Stealy Medical Group is part of San Diego-based Sharp Healthcare, one of the biggest health systems in California, with four acute care hospitals, three specialty hospitals, and three affiliated medical groups.

In the past, case managers would identify people who needed support, try to contact them, and explain what assistance they could provide. Usually, only about half of the calls resulted in patient engagement, Appel reports.

"We were unable to provide care management services to a segment of the growing population with the staffing resources allocated," Appel says. "The mobile texting program has allowed us to increase case management capabilities by 44%."

Texting allows the nurses to support more patients over a longer period of time than they could with traditional outreach, Appel says. "Through our texts, we provide guidance and tools to help them through the recovery process. It also allows us to be there when they need it if they encounter setbacks," she says. The text messages help patients with their discharge instructions, identify early signs and symptoms of potential issues, and promote behavioral change, Appel says.

The text messages include alerts, reminders, and tips for managing each condition. Among the topics available by texting are diabetes, pre-diabetes, medication adherence, weight management, hypertension, healthy living, and post-hospital discharge.

"We're always making changes, adding more topics, and more messages to each topic," Appel says.

Patients can choose to receive messages at the frequency they desire, Appel says.

"We tweak the program to meet the needs and preferences of the patient," she says.

The texts are perfect for patients who don't want to spend a lot of time on the phone talking to a case manager, but who can benefit from care coordination, Appel says.

The text messages include information and reminders that patients can read quickly. They remind patients to take their medicine at scheduled times, describe symptoms and signs that mean patients should call the physician office, remind them to schedule follow-up visits with their physicians, provide tips on staying healthy, and offer information on fitness activities and local support groups.

For instance, patients in the medication management program receive messages like "Take your medicine as prescribed even if you feel good" and "Your medication is needed to prevent serious complications."

Examples of the healthy living program texts include reminders for the patients to eat vegetables, fruit, and lean meats and fish, and to stick to the outside aisles at the supermarket where the fresh foods are.

The messages sent to post-hospital patients remind them to schedule a follow-up appointment and to follow their medication regimen and include information on a nurse line in case the patients have questions.

The system also allows patients with a question or a concern to reply with a text message that goes to a dashboard monitored by a Sharp case management assistant who can contact the patient with an answer or escalate the message to a nurse if the question is clinical.

The diabetes texting program lasts six months, but patients can sign up again. Healthy living and hypertension are open-ended.

Patients are identified for the

program in a variety of ways, including data mining and referrals from physicians or other providers. For instance, potential participants in the diabetes program include patients with a new diagnosis of diabetes, patients with uncontrolled diabetes, and referrals from physicians.

Community health workers contact many of the patients and sign them up for the program. Others may be recruited by the entire clinical staff, including nurse case managers embedded in the physician office who see the patients when they come for their post-hospital follow-up visit.

Whenever staff members talk to patients who need support, they try to get the patients to enroll in the appropriate program, Appel says. The patients receive a text message asking if they want to be part of the program while they are still on the telephone with the community health worker or other member of the population health team. If they agree to sign up, they text back the word "yes."

More than 3,000 people participated in the texting program last year. ■

Hospital's Model Cell Uses Case Management Best Practices

At McLeod Regional Medical Center in Florence, SC, a multidisciplinary team created a "model cell" where case management best practices are adapted to meet the needs of the hospital and where new employees receive their training.

"The model cell operates the way we want the case management process to work on all floors. It helps us work the kinks out of best practices and to create standard processes to be used throughout the hospital," says **Reeana Henderson**, RN, associate vice president of case management for McLeod Health.

The goal is to eventually use the model cell to implement model floors throughout the organization, Henderson adds.

The team created the model cell using an operational Lean process with a goal of clarifying case management roles and providing consistent assessment and discharge planning throughout the hospital, Henderson says. "We have worked on every aspect of the case management process, sometimes more than once," she says.

The 461-bed facility, the flagship hospital for McLeod Health, has three towers, with a case management manager assigned to each. The case management department was reorganized in 2016, shifting from a triad model to dyad model. An average of 28 case managers are on duty on any given day and each has an average caseload of 15 patients. A total of 16 social workers cover the hospital.

The department also has seven extenders who help with clerical work, and three nurses who work remotely with the utilization compliance team on concurrent denials and peer-to-peer secondary review.

"When we changed models, people quickly went back to their old way of doing things. The nurse case managers and social workers were struggling to follow the new model. The responsibilities were clear and well-delineated, but the staff was not seasoned enough to completely understand their role," Henderson says.

The triad model had three separate and distinct roles: RN case managers, social workers, and utilization review nurses, Henderson says.

Now, under the dyad model, case managers are responsible for assessments, care coordination, utilization review, and discharge planning. The social workers handle the psychosocial issues and partner with case managers on complex discharge planning.

The case management team began its Lean initiative on the hospitalist floor. "The hospitalists had moved to geographic rounding which made it easier to develop a model floor and have everybody buy in," Henderson says.

Members of the Lean team included Henderson, the case management managers from nursing and social work, the manager of the operational effectiveness staff, the case managers, a social worker, and an extender who are assigned to the floor. All of the team members have completed Lean training.

When the team reviewed long-stay patients, they found that many of the issues delaying discharge were at the front end, Henderson says.

"Much of the staff was new to case management and there was not a good training process. As a result, the assessments were not consistent, the transitions were not going smoothly, and there was not a specific process for the staff to follow," she says.

One of the objectives of the

project was to clarify all the roles so everyone in the department would be clear on who is doing what, where documentation takes place, who is responsible for each day-to-day task, and how multidisciplinary rounds should be conducted, Henderson says.

When the team developed a new process or recommendation, they tested it on the model cell.

The hospital is rolling out the processes created during the Lean pilot throughout the hospital this spring, making minor changes on individual floors based on the types of patients and processes.

As part of its ongoing improvement work, the case management department created a referral placement center staffed by extenders who work on placements in skilled nursing facilities, assisted living facilities, and swing bed facilities.

"In the past, social workers and nurses all over the building were sending placement queries all day. Now with the work centralized in the referral placement center, it saves staff time and a lot of calls," Henderson says.

One of the biggest projects for the team was creating an electronic dashboard that gives the staff all over the hospital an instant view of what is going on with each patient.

The dashboard, created by modifying the hospital's teletracking patient flow tool, helps the staff manage patients' daily improvement. For instance, if the case manager determines that a patient no long meets medical necessity, the patient's slot on the dashboard turns red.

"This helps with patient flow by alerting the staff when patients need to be moved from a unit. If there are a significant number of patients who need to be moved to another level of care, the case management manager knows that the case manager on the unit may need extra help," Henderson says.

There are tabs to alert the referral placement center when patients will need a post-acute placement. The dashboard also lets the staff know when a discharge is pending and when a bed is available. There is a box that shows if the Important Message from Medicare has been delivered.

"We use the teletracking tool to help with a variety of tasks and it also helps us identify where case managers may be struggling," she says. After the team worked out the glitches in the teletracking process in the model cell, the hospital rolled it out to other floors.

The team also developed a daily improvement board that hangs in the nursing break room that cites three goals each month. One of the goals is to discharge 50% of patients by 1 p.m.

"The goal of the Managing for Daily Improvement initiative is for everybody — the case managers and the nursing staff — to take ownership for what happens on the unit. The staff is responsible for going over the board every day before afternoon rounds and noting their progress toward the goals," she says.

The department also has instituted mandatory daily interdisciplinary rounds and created a format for the staff to follow.

When the rollout is completed, each unit will have multidisciplinary rounds in the morning and afternoon rounds to discuss what is likely to happen the next day. In addition to the case management staff, the multidisciplinary rounds will be attended by the hospitalists, nursing representatives, and representatives from other ancillary services that are part of the care team.

When new case managers are hired, they go through training in the model floor. "Instead of working with preceptors who have no formal training, they spend time on the model floor. This way, everybody has the same training," she says.

Many of the department's new hires do not have case management experience, but they do have expertise in the area for which they will be assigned, Henderson says. For instance, if there is an opening on the surgical floor, Henderson looks for a nurse with experience in a surgical area and who has the collaborative and critical thinking skill set. "It's essential for case managers to be people who can take ownership of things," she says.

New case managers spend a week with the staff development coordinator and then spend four to six weeks on the model floor, working with one of the nurse case manager before going to their assigned floor. Then, they undergo 30-, 60-, and 90-day competency checks.

Henderson and her team have collected data from every floor in the hospital and are using it to create a staffing chart that bases each unit's staffing on the workload.

"We were staffed at 1 to 15, but no one took into account that some floors are busier than others. For instance, the surgical floor typically has 12 admissions a day while other floors may have four admissions," she says.

The team pulled data for each unit and analyzed the number of admissions and transfers in and out each day. They calculated the average time it took to complete an InterQual assessment and other tasks case managers performed each day to get a picture of the work process of each unit.

"The data will enable us to base

staffing on each floor on what the patient population is like on the floor," she says.

For instance, the surgical unit has more admissions on Tuesday and Wednesday. On another unit, a significant number of patients are discharged each day.

"We are analyzing data from throughout the hospital to determine if we need to change the way we assign duties," she says. ■

Readmission Rates May Not Reflect Quality, Study Says

The public has been led to believe that hospital quality measures on CMS's Hospital Compare website offer a simple but reliable way to compare the quality of care offered by different hospitals, but recent research casts doubt on that reliability.

Hospital readmission rates in particular have gained substantial attention from policymakers and healthcare providers because of their high frequency and significant costs. Researchers at the Smith Center for Outcomes Research in Cardiology at Beth Israel Deaconess Medical Center (BIDMC) in Boston say condition-specific readmissions measures may not accurately or fairly reflect hospital quality.

The study found significant differences in hospitals' performance when readmissions were assessed for non-Medicare patients and for conditions other than those currently reported. When these additional factors are taken into account, half of hospitals would be subject to a change in their financial penalty status, the researchers say.

"Medicare metrics alone may not be the final word on hospital quality for readmissions," senior author **Robert W. Yeh**, MD, MSc, director of the Smith Center for Outcomes Research in Cardiology at BIDMC, said in a statement announcing the study results.

"As it currently exists, the Medicare public reporting system offers an incomplete picture," Yeh said.

"Significant attention has been given to hospitals' overall performance as determined by the public reporting of a small number of specific conditions and patient populations," he added. "It's a little bit like issuing a final grade based on a few homework assignments and not a full semester's worth of work."

Excess readmission ratios, which examine hospital readmissions for heart failure, heart attack, and pneumonia among Medicare beneficiaries, are used to assess quality and determine hospital payments. Yeh and his colleagues wanted to know if hospitals that reported high readmission rates for fee-for-service Medicare patients also would have high readmission rates for patients with other payers, including Medicaid and private insurance.

They also wanted to find out if hospitals with high readmission rates for the three specified conditions — heart failure, pneumonia, and heart attack — had similarly high readmission rates for other unreported conditions, says first author **Neel Butala**, MD, MBA, an investigator at the Smith Center at BIDMC and cardiology fellow at Massachusetts General Hospital.

The researchers reviewed data from the Healthcare Cost and Utilization Project's Nationwide Readmission Database, focusing on more than 2,100 hospital observations in 2013 and 2014 to investigate whether 30-day readmission measures for heart failure, myocardial infarction, and pneumonia among Medicare patients reflect hospital performance on readmissions more broadly in an all-payer national sample.

They found that 29% of hospitals currently being penalized for readmissions would no longer incur a penalty if unreported conditions were used as the basis of the calculations.

The difference was even greater when examining non-Medicare readmission rates: 40% of penalized hospitals would no longer be issued penalties if performance was based on readmission rates for non-Medicare patients hospitalized for heart failure, pneumonia, or heart attack.

"This tells us that similar hospital or patient characteristics may influence readmissions more than similar disease conditions and suggests that efforts to prevent readmissions may be more successful by targeting hospitalwide processes rather than condition-specific processes," Butala says.

An abstract of the study is available online at: https://bit.ly/2J2lKHp. ■

Staff Workarounds Pose Medication Error Risk

Patient safety is compromised when healthcare workers use workarounds to speed things up when they are busy, or to overcome roadblocks that make it difficult or impossible for them to follow proper procedures in the medication process, warns a recent report from the Pennsylvania Patient Safety Authority (PPSA) in Harrisburg.

The good news is that recognizing those workarounds provides quality leaders the opportunity to redesign the work process so that clinicians are not tempted to deviate from the procedure.

In its work with Blue Mountain Health System in Lehighton, PA, to identify barcode medication administration (BCMA) risks, PPSA found a pattern of near-misses involving a commonly used drug administration check tool that uses point-of-care barcode technology to automatically validate and document the medication administration process. The system is intended to improve patient safety by reducing medication errors.

The health system's data indicated multiple instances of barcode scans of the wrong patient as the nurse administered medication at the bedside, which generated error reports for each one. When the health system and PPSA investigated, they found that these incorrect barcode scans were intentional: Nurses were not clearing the previous patient from the barcode scanner because it was faster and easier to leave the previous patient info in the system. Following the proper procedure to clear one patient before scanning the next required too many mouse clicks and slowed down their work, the nurses reported.

"To understand the nurses' barcode scanning workflow better, the team surveyed nursing staff about their scanning process, including whether they scan the medication or the patient first. The existing policy set an expectation that the patient is scanned first, then the medication," the PPSA report explains.

"However, nurses would engage a workaround in certain circumstances (e.g., when the same medication was ordered for multiple patients [e.g., acetaminophen], nurses would first scan the medication). This workaround contributed to some of the wrong-patient scan totals. In addition to policy re-education, nursing directors affixed a STOP sign visual reminder to the mobile computers, which reinforced the proper scanning sequence. This reminder helped reduce the number of wrong-patient scan errors."

Lack of internet connectivity also led to staff employing workarounds that they thought were the best alternative to following the standard procedures.

"For example, the health system noted certain patient rooms had greater numbers of barcode scanning events than others, which was associated with limited or no internet connectivity," the report says. "Internet connectivity was expanded to include those areas." ■

CMS Urges Security in Texting Clarification

In an updated memo, CMS reinforced its policy that texting of patient orders is prohibited and Computerized Provider Order Entry (CPOE) is the preferred method of order entry by a provider. CMS wrote that it "has held to the long standing practice that a physician or Licensed Independent Practitioner (LIP) should enter orders into the medical record via a hand written order or via CPOE. An order if entered via CPOE, with an immediate download into the provider's EHR, is permitted as the order would be dated, timed, authenticated, and promptly placed in the medical record."

CMS says texting patient information among members of the healthcare team is permissible if accomplished through a secure, encrypted platform. But CMS wants organizations to implement procedures that routinely assess for any security breaches in order to avoid negative outcomes that could compromise patient privacy per HIPAA regulations.

The memo can be found at: https://go.cms.gov/2As9SJ2. ■

COMING IN FUTURE MONTHS

- Maintaining security and patient privacy in electronic records
- How hospital case managers can plan the day's work

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log on to AHCMedia.com, then select My Account to take a post-test.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, a credit letter will be emailed to you instantly.
5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CE QUESTIONS

1. **When a new patient is registered in the ED, which of the following applies to the offsite case manager?**

   a. Being alerted to the new patient
   b. Seeing all documentation necessary to determine whether the medical record supports the patient's status
   c. Working with the physician or the ED case manager while the decision is being made to admit or begin observation services
   d. All of the above

2. **According to Vivian Campagna, MSN, RN-BC, CCM, when utilization review is separate from case management, which of the following activities should case managers focus on to avoid readmissions?**

   a. Taking a longer lunch break
   b. Shredding prior flowcharts and unnecessary paperwork
   c. Giving the patient resources in advance of discharge
   d. All of the above

3. **According to Beverly Cunningham, MS, RN, ACM, a hospital that uses a dyad model due to very challenging payers could eliminate this problem by having a strong appeals department that works with payer contracting and payer relations.**

   a. True
   b. False

4. **According to Janet Appel, RN, MSN, CCM, a program that sends secure text messages every day to help at-risk patients manage their conditions resulted in a 22% decrease in 30-day readmissions and how much improvement in 90-day readmissions?**

   a. 6%
   b. 32%
   c. 46%
   d. 56%

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.