HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Hospitals and Colleges Collaborate in Health Coach Training Programs

Case management-style program helps students and patients

By Melinda Young

Some small-town hospitals and colleges have found a way to provide pre-med, nursing, and allied health undergraduate students with hands-on medical experience that benefits the community. The student health coaches perform case management-type services for at-risk patients.

Called health coaches, these students learn skills years ahead of their peers. They receive college course credit and volunteer or internship experience. And, they contribute to positive health outcomes, including keeping patients out of hospitals and EDs.

> "[STUDENTS] DEVELOP RELATIONSHIPS WITH THE PATIENTS AND START TO BREAK DOWN THOSE BARRIERS BETWEEN THE HEALTHCARE COMMUNITY AND PATIENT."

"The patients love it because they love the students, and we can find out so much more about what's going on with patients because of the students being there in their homes," says **AlexSandra Davis**, RN, BSN, MPA, director of home health services/Community Care Network at Wooster Community Hospital in Ohio.

The program is successful with patients and students, Davis says.

For instance, Wooster's private internal data show that patients with diabetes improved their hemoglobin A1c levels, and reduced ED visits and

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AUTHOR: Melinda Young
AUTHOR: Jeanie Davis
EDITOR: Jill Drachenberg
EXECUTIVE EDITOR: Shelly Morrow Mark
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS MANAGER: Amy M. Johnson, MSN, RN, CPN

EDITORIAL QUESTIONS
For questions or comments, call Jill Drachenberg at (404) 262-5508.

hospitalizations. For all diseases, ED visits declined 38% and hospitalizations dropped by 36%.

Wooster Community Hospital collaborates with the College of Wooster to run the program, which started in 2013 after nearly a year of preparation. The idea came from a care management-style program implemented in 2012 by Meadville Medical Center and Allegheny College in Meadville, PA.

"Our program has been in place for seven years and has had over 14 semesters worth of students that have cared for patients," says **Tracy Meure**, BSN, director of the Community Care Network at Meadville Medical Center.

About 40 students work with patients each semester, she says.

"They develop relationships with the patients and start to break down those barriers between the healthcare community and patient," Meure says.

The students visit patients weekly and learn to observe changes, including small things that could signal a major health issue.

For example, one Allegheny College health coach noticed a patient would cough when drinking water. The student reported this change to the health coaching team at a weekly meeting, and the team sent a healthcare professional to examine the patient for swallowing problems, Meure says. It turned out the patient experienced difficulty drinking water. The patient needed therapy to improve swallowing and prevent pneumonia or another respiratory disease, she adds.

"The student reported something she noted that was out of the ordinary for that patient, but didn't know the relevance of what she was reporting," Meure says. "We, as a clinical team, could identify the problem."

In another example, a student health coach worked with a patient who had visited the ED 23 times in the year after her husband died, Meure recalls.

"All of her visits were in the evening, and some of them involved random symptoms that could have been because she was lonely," Meure says. "We put a health coach in place, and once the woman knew there was something to look forward to — a weekly visit — she was only in the emergency room once."

Finding college professors and volunteers from the hospital to help with the Wooster program was fairly easy, Davis notes.

"We had so many volunteers from the hospital, who were willing to teach, and we had so many partners," Davis says.

The timing of the program coincided with the rise of accountable care organizations

EXECUTIVE SUMMARY

Hospitals and colleges can collaborate to give undergraduate students experience working with patients in a case management-style model.

- Students are health coaches and meet with at-risk patients once a week.
- Health coaches get to know patients and provide them with friendly companionship, and promote improving healthy habits.
- The health coaching model benefits all stakeholders, including students, patients, the hospital, the college, and the community.

(ACOs), as population health/care management models were gaining acceptance across the healthcare spectrum.

"How to manage really sick patients was a priority for many physicians because they were under the gun to manage their patients better," Davis says.

The health coaching model was born when a Meadville Medical Center doctor observed a disturbing trend of patients returning to the ED multiple times at an enormous cost, says **Steven Farrelly-Jackson**, DPhil, associate professor of philosophy and global health studies and coordinating professor of the Health Coaching Program at Allegheny College.

"The idea was to extend care into the community to prevent readmissions and to prevent people from having catastrophic health breakdowns," Farrelly-Jackson says. Meadville Medical Center and Allegheny College officials met and discussed a plan for the internship program.

The Health Coaching Program typically has 20 students in the seminar portion and 20 in the health coaching portion in a given semester. Students begin with the seminar to learn about community healthcare before they launch into real-world experience, Farrelly-Jackson says.

"We have a lot of students who are pre-health," he says. "They are biology, biochemistry, global health studies, pre-health track majors planning to go to medical school, physician assistant school, or go into nursing."

There up to 100 health coaches at Wooster, working with about 120 patients, Davis says. Students who enroll in the program are entering the healthcare field, including professions in medicine, dentistry, and dietetics.

"I've had several students who just graduated from medical school, and they say this program really prepared them for medical school," Davis says. "They were so far ahead of other students — already knowing how to take care of patients, document care, and present their cases."

One former health coach now is working in a hospital training to be a neurologist, she adds.

Student health coaches often develop a special bond with the patients they serve, says **Kirsten Peterson**, MA, director of pre-professional studies and global health studies at Allegheny College. Peterson also works with health coaches.

"Patients tell students things they would never tell their doctor and nurse," Peterson says. "They get to know them and trust them."

Students also learn hard lessons about how difficult it is to help people change their behaviors. Peterson learned from one student that his client was a man who needed to lose weight and exercise. The student devised an exercise schedule and envisioned the patient walking one mile several times a week by the end of the semester.

"Then he got in there, meeting with the man, and realized that his schedule would not work," Peterson recalls. "By the end of the semester, the patient was able to leave his house and walk out to the sidewalk, which was very different from walking a mile every day."

However, the health coach helped the patient reach the program's goals. The man was able to get out of his house, stay healthy enough to continue living at home, and to achieve the highest quality of life possible under the conditions, she adds.

"Particularly with these older folks and with patients with low mental capacity and all sorts of mental health problems, you don't make these huge scale changes," Peterson says. "They come in increments, and that's an incredibly important lesson for students to learn. It gives them a much more realistic view of conditions, diseases, and what can be done." ■

The Inner Workings of a Health Coaching Program

Hospital case managers and others interested in extending case management through the use of student health coaches can implement a health coaching program with a local college.

Both hospitals and colleges can benefit from the collaboration. A program can be created with the following steps:

• Obtain referrals, and provide staff and resources. "A lot of referrals we get are from case managers, especially for the patients that have been in the emergency department and are 'frequent fliers,'" says **AlexSandra Davis**, RN, BSN, MPA, director of home health services and Community Care Network at Wooster Community Hospital in Ohio.

When invited, patients can choose whether to participate. The hospital pays for staff to support the program, including Davis' job, a clinical manager, and two licensed practical nurses (LPNs), she says. The health coaches are student volunteers, and other resources come from fundraisers.

"Even employees at the hospital have engaged in supporting the program," Davis says. "We raised $20,000 in the community to purchase blood pressure machines and scales that we can offer free to patients."

The program also gives patients a medication dispensing machine that costs more than $200, plus $20 per month for upkeep.

"These machines are so valuable that we haven't had any patients (using the dispensers) admitted for medication issues," she says. "We teach students and staff to fill the medication minder boxes with the patient's medication, and then we set the machine to light up and send an alarm for the patient to take the meds."

The dispensing machines open the medication holder. If the patient does not take the drug, the alarm reactivates and the patient is called by the company that monitors the machine, Davis adds.

> "THE PURPOSE OF THE PROGRAM IS TO NOT HAVE STUDENTS DO THINGS FOR PATIENTS, BUT TO FIGURE OUT WHAT PATIENTS ARE WILLING TO WORK ON AND TO HELP THEM DO THAT."

• Recruit students. Students can be interns or volunteers. They also can earn college credit for attending the seminar on health coaching and for working with patients.

But these are not the reasons students apply to the program, notes **Kirsten Peterson**, MA, director of pre-professional studies and global health studies at Allegheny College in Meadville, PA.

"Students are drawn to health coaching primarily because these are students interested in working with people, often in the health field, but sometimes in social work and psychology," Peterson says. "There are very few ways that an undergraduate can get that experience, especially for pre-med and pre-health students."

The student health coaches learn firsthand how the healthcare system works, including about health disparities. They meet with doctors, nurses, nutritionists, and other professionals, Peterson says.

"The students assist care coordination departments of hospitals and serve as health coaches, part of our care management team," says **Tracy Meure**, BSN, director of the Community Care Network at Meadville Medical Center in Pennsylvania.

Student health coaches also benefit when they apply to graduate programs in healthcare, says **Steven Farrelly-Jackson**, DPhil, associate professor of philosophy and global health studies, and coordinating professor of the Health Coaching Program at Allegheny College in Meadville, PA.

"When they apply to medical school, they immediately stand out because they have this background," he says. "The medical school interviews focus a lot on the health coaching work they have done, so there are all sorts of benefits."

• Hold seminars and didactic learning. At Wooster, the didactic portion covers these three sections:

- Introduction, including the role of the health coach and lectures about the state of healthcare and metabolic disorders, including morbid obesity;

- Diseases, including chronic illnesses such as diabetes, chronic obstructive pulmonary disease, congestive heart failure, and hypertension;

- Communication, including information about the teach-back method, and how to interview patients.

"We also have someone from hospice come in to talk about palliative care and hospice care," Davis says. "We have a social worker who talks about depression, anxiety, and suicide, and we have a dietitian who talks about nutrition and disease."

Students also practice their interviewing skills. They divide into two groups: One person portrays a patient, and others interview the patient about nutrition, social issues, transportation, and living environment, Davis says.

"Then they write a care plan in class and present the care plan to the other group, answering questions from the other group," she explains.

• Prepare for patient encounters. A Community Care Network nurse accompanies students for the first patient visit, Peterson says.

"The purpose of the program is to not have students do things for patients, but to figure out what patients are willing to work on and to help them do that," she says. "It could be helping patients increase their mobility, doing exercise, going for a walk — that kind of thing. The premise is that the patient is in charge."

Student health coaches can receive clinical competency training that includes measuring blood pressure; assessing for stroke; monitoring blood sugar, balance, weight, and pulse oxygenation; and performing hand hygiene and head-to-toe assessments.

Nurses serve as clinical managers, overseeing student health coaches as they work with patients.

"The students are considered volunteers, and that's a critical point," Davis says. "After a referral, we go out to patients' homes first and do an assessment to see if the patient is appropriate for the Community Care Network."

If the patients are a good fit, they are offered a consent form that will allow health coaches to visit and work with them.

Students work with staff to develop a care plan and learn the subjective, objective, assessment, plan (SOAP) documentation method.

"That's what they use in medical school," Davis says. "They are taught to document and how to present their case."

A staff member accompanies students on their first visit with patients. "We ask if they're comfortable going back on their own or if they need us to go back with them a second time," Davis says.

• Have health coaches visit patients and present cases. When student health coaches visit patients, they are responsible for knowing the patient's medications, side effects, diagnoses, and the care plan.

"They have to be able to do a head-to-toe assessment and know how to do the SOAP documentation notes after the visit," Davis says.

At team meetings on Tuesdays and Thursdays, students present their cases to the group, which consists of a co-medical director, clinical manager, LPNs, and a social worker. The professionals listen to the students' presentations and ask questions, having them explain what the next plan of care will be, she adds.

"They also have to connect with their supervisor and present what's going on with the patient so the supervisors know exactly what's happening. We're ultimately responsible for that patient," Davis says.

• Teach students about healthcare work challenges. "Students learn very quickly about patients' depression and the effects of family situations," Peterson says.

Another, often unexpected aspect to working with an at-risk medical population is patient deaths.

"When students lose a patient, we take them out to lunch and we talk about how hard it is for them," Davis explains. "We try to be compassionate with them as some of these students have never lost a grandparent or even a pet, and this is a whole new experience for them."

The Wooster health coaching program also has brought in palliative care and hospice instructors. Patients enrolled in the program can be referred to these services, as needed.

"Sometimes, patients who seem to be doing well take a serious turn for the worst," Peterson says. "That's real hard on the students who have seen that."

For example, a student health coach was working with a pregnant patient who then suffered a miscarriage.

"The student was the person [the patient] wanted with her, and that was really rough," Peterson says. "I know that student well, and now she's applying for medical school. The student is even more determined now to go into medicine and be that person who can help in those situations."

On the positive side, another student health coach invited her patient to attend a sorority tea for families when the student's own family was unable to attend.

"Her patient was thrilled to play that role," Peterson says. ■

Patient Activation Is a Health Promotion Method That Works

Patients can reach education goals

Case managers continually learn new methods to educate and engage patients. The key is to find the right method for case managers to achieve their patient education goals.

Patient activation may be one such method.

"What it means is patients are engaged and understand what they need to do to improve their health, and they're motivated to do it," says **Mary McLaughlin Davis**, DNP, ACNS-BC, NEA-BC, CCM, senior director of care management for the Cleveland Clinic Health System.

Davis describes three important patient activation methods and tools:

• **Use the PAM method.** The patient activation measure (PAM) was founded by Judith H. Hibbard, DrPH, who published this tactic for measuring activation in patients in a 2004 paper. *(More information on the method can be found at: http://bit.ly/2EUBuLT.)*

PAM is based on the theory that there is a great deal of variation in patient activation/engagement in a patient population. Some patients need more support, and should be evaluated to see what works.

"When a case manager engages with patients, is the case manager able to connect so that patients clearly understand what they need to do to help themselves get better and stay better?" Davis says.

Patients who are passive in their own care, even if they are adherent and compliant to their health regimen, struggle more than patients who are engaged and taking charge of their own health, she adds.

These are the PAM levels:

- First level: A patient has no idea how to improve his or her health. This could be a patient who recently suffered a stroke and is in the neural ICU. To this person, there is no connection between his or her daily doughnut habit, high cholesterol, and stroke, Davis explains.

"WHEN A CASE MANAGER ENGAGES WITH PATIENTS, IS THE CASE MANAGER ABLE TO CONNECT SO THAT PATIENTS CLEARLY UNDERSTAND WHAT THEY NEED TO DO TO HELP THEMSELVES GET BETTER AND STAY BETTER?"

- Second level: At this stage, a patient is starting to accept that there is a cause and effect between diet, exercise, smoking, and health crises. "They start to say, 'Maybe eating all that junk food really did have this kind of impact,'" she says.

- Third level: "At the third level, patients make a connection and they own it, saying, 'Yeah, I'm going to have to cut back on those doughnuts,'" she adds.

"They might say, 'Instead of eating two doughnuts a day, I'll eat one a week.'"

- Fourth level: This is where the person is in stroke rehabilitation and in a stroke support group, and he or she is picking up people and driving them to the stroke support group, Davis says.

"They're baking healthy cookies or bringing fruit for stroke support. They are taking care of themselves, exercising, and being fully engaged," she explains.

"You can go in and out of those stages," Davis adds. "You could be a level four as far as the stroke is concerned, and then you get a cancer diagnosis, which understandably throws you for a loop, so you digress to a three or two."

• **Learn patient activation assessment.** The patient activation assessment (PAA), developed by Eric Coleman, provides another model for coaching patients to improve their health. *(Learn more at: http://bit.ly/2LDtbIB.)* PAA includes four columns:

- Medication: There are 10 questions/points, including this example: "Demonstrates ability to accurately update medication list."

- Red flags: This includes questions about the patient's condition and whether the patient knows if it is getting worse. There also are questions about signs and symptoms of another episode.

- Follow-up: This ensures patients know how to get help when they need it. One item is: "Can schedule and follow through on appointments."

- Personal health record: Case

managers ensure patients understand their personal health information, know how to keep it updated, and carry the book to all appointments.

"I've found that if patients do not have a certain level in their activations scoring in both tools, they are not able to be discharged from acute rehabilitation," Davis says.

• **Try motivational interviewing.** This involves asking patients questions that will link their skills to a goal they might achieve to improve their health. Motivational interviewers are trained on the values of quality, openness, generosity, and respect. *(More information and tips can be found at: https://bit.ly/2M9FX1F.)*

For example, Davis recalls a patient who had been a scientist prior to a devastating stroke. He lacked physical function and was in rehabilitation.

"He had a tremendous interest in technology, so the nurse working with him found an app that could measure his blood sugar and help him with managing his blood sugar," she says. "He really liked the app, and it gave him some independence."

Through motivational questioning, the nurse was able to find out what the patient's interests were prior to the stroke. His answers gave her the idea for a technological solution that would work for him, Davis says.

The methods are difficult to employ, particularly when a patient is in an acute care setting, Davis notes. But a patient activation strategy can work in a hospital setting.

"It also is a great strategy for case managers to use in ambulatory settings or telephonic work," she adds. "Often, patients have goals that have nothing to do with their health, and my job as a teacher and case manager is to bring a patient to their goal and use motivational interviewing to do it. Taking the doughnut analogy, a patient could be comfortable with his doughnut habit, but over the years it adds weight and raises glucose levels." A person with the doughnut habit could become diabetic and have high cholesterol levels.

"So, you say to the patient, 'Now, you're in kind of a predicament. Where would you like to see yourself in three months?'" Davis says.

"The patient might say, 'I'd really like to take my 4-year-old granddaughter to a baseball game like I could before. In fact, she's the one I have doughnuts with.'"

The case manager can say that with therapy, this goal could be attained. Also, the case manager might ask the patient to think about how he could take better care of himself so he can spend more time with his granddaughter, she adds.

"You could tell him, 'Instead of two doughnuts per day, how about three doughnuts with your granddaughter each week, making it a special time when you go out for doughnuts?'" Davis says.

"Don't take everything away from patients because that is so hard," she adds. "But encourage them to take things away from themselves because they see the value in it." ■

Avoiding Denials for Transitions of Care

By Jeanie Davis

Too often, a patient's claim for post-acute care is denied for reasons that are entirely preventable, says **Janeen Foreman**, corporate director of case management for LifeCare Management Services based in Dallas/Fort Worth.

This transition may include either rehabilitation or palliative services in a facility, ongoing outpatient therapy, or care provided at home. These authorizations are scrutinized closely by both payers and regulatory bodies, so it is critical that hospital case managers know how to avoid denials, Foreman explains.

"The major problem: People don't understand the contractual agreement with the insurance company," she explains. "Whatever the stipulations are, you've got to follow them."

Questions to consider include:

• What does the contract say is necessary?

• Do you have to notify on admission or prior to admission?

• Is there a 24-hour window for notification?

• If the procedure is prescheduled, does the patient have the medical tests necessary for that procedure?

• Has the patient verified approvals with the physician's office?

"To stop denials, you have to make sure you're meeting contractual obligations," Foreman says. "It's all about knowing your contract and making sure you meet all the stipulations."

Has clinical information been documented by all disciplines? Does it support the level of care the patient is receiving? Is ICU care necessary? Does the patient need an ICU-level nurse and constant monitoring?

"Each hospital has defined what qualifies a patient for that level of

care," Foreman says. "If you're not meeting it, is the patient not sick enough for that level of care — or is it not being documented properly?"

Does the physician and staff documentation support the level of care the patient is receiving? "If the ICU standard is vital signs every two hours and it's being done every four hours, that's a problem," Foreman explains. "If the doctor is saying the patient is stable and we can discharge him home in a day, do they still need ICU-level of care? Could he be moved to a lower care unit?"

Review Patient Documentation

The patient's medical record is the focus for all this critical information. "Attention to detail is key," says Foreman. "You also have to know what criteria you're using to measure patient status. We anticipate patients at a specific level will need a certain level of care. If patients don't meet those criteria as documented in the record, that's a problem."

When an authorization or claim is denied, it is critical to follow a specific appeal protocol.

Questions that must be addressed include:

- Is this a Medicare denial?
- Which payer is denying?
- Is it a complete denial, or a partial denial?
- Is it a denial because the insurance company says the patient should have been in a different level of care?

If the diagnosis-related group (DRG) has changed, a denial must be appealed.

"If the agreement carves out days for services but the patient's hospitalization has been longer, the insurance company won't pay for those days," says Foreman. "If the patient is assigned to a specialty bed but the insurance company is not notified, there might be denial."

Types of Denials

The appeal should be made through utilization review or case management — whoever is updating the insurance company, she adds. "The critical factor is open line of communication between you and the insurance companies."

The type of denial is an important component. Administrative denial occurs when contract terms are not followed. A "not medically necessary" denial can be made for a variety of reasons — often because the physician skipped a step, like a diagnostic test.

An experimental or investigational procedure will not be covered. Mental health services might not be covered.

The patient might not be eligible for certain services. For example, bariatric surgery involves a very strict protocol for approval. Insurance companies refuse to cover this if there is no preauthorization or precertification.

The billing time window also is critical. If the filing is not prompt, or if there is an error in billing, the claim will be denied. Insurance companies will conduct a chart-to-charge audit, looking at whether charges match the documentation — even down to medication doses.

If a denial occurs, the appeal must be planned very carefully, says Foreman. "First, remember that the insurance company's case manager hasn't seen your patient."

Review documentation to ensure accurate descriptions and adequate details about each patient and illness. The team's documentation — what is in the patient's record and what is not — can substantiate the appeal, says Foreman. Or, it can make an appeal impossible.

"If the medical record is rich with clinical documentation, and clearly written, your case will be good," she explains.

The next step is to review the contract. What level of appeal are you going to make? Is it concurrent while the patient is in-house? Is it prior to admission or retrospectively after discharge? Each insurance company has several levels of appeal based on the contract.

Try Peer-to-Peer Review

Before filing an appeal, request a peer-to-peer review. "The attending physician will provide information about the patient to the insurance company's physician," Foreman explains. "They will talk one-on-one. Very often, the denial can get overturned there because they understand each other. This can clear up the miscommunication immediately."

Ensure that the physician is prepared for success, Foreman advises. "Help him or her know what's going on, why the case was denied, and what information has already been provided to the insurance company."

Take the following steps to prepare the peer physician:

- Provide the peer physician with a brief summary of the medical history, the current problems, and the proposed treatment plan;
- Tell the peer physician what conservative treatments were used, including medications and dosages;
- Outline specific details about why this patient needs this care for this specific condition, why inpatient

care is necessary, and what length of time is required for the treatment (the physician can express this last point as "based on my experience, this is expected").

Also, prepare the physician for what not to say, says Foreman. "You don't want any impassioned pleas; instead, talk about outcomes and evidence. You also don't want them to agree with a watch-and-see approach. That's viewed as withdrawal of referral for admission."

There also should be no talk about payment levels or amounts, she adds. "You don't want the physician to agree that the hospital will pay. You don't want the physician to get involved with specific individuals' considerations. The insurance companies have policies and procedures that must be followed, period."

Keep the discussion focused on the patient, she advises. "If the doctor doesn't agree with the peer's decision, tell them in the phone call, 'I don't agree,' and tell them their opinion is being recorded in the patient's record so you can appeal again."

Nearly 75% of denials can be overturned with these methods, Foreman says.

For 100% approval, "do it right in the first place," Foreman advises. "Get everything lined up, including the documentation, and you are pretty much guaranteed of meeting the contractual obligations and getting paid."

The bottom line is: "It's really about the doctor stating what's wrong with the patient, progression of the care, the patient is getting better, moving them forward, planning their discharge on admission, still looking at the end date, when the treatment will be complete."

In getting the patient approved for post-acute care, the focus must be on medical necessity of the next level of care, whether it is rehabilitation, skilled nursing, or long-term acute care.

The physician plays a key role, as does case management. The coding has to line up with what the physician prescribed. If the physician does not document completely what is happening to the patient — if DRGs are not what the physician anticipated — that is when denials occur.

If the physician lists a DRG for respiratory failure, but the patient ends up with a COPD DRG (that was not clearly documented), there can be a reduction of payment, says Foreman. "The resource consumption may be different than what's supported by the DRG."

Documentation is the key to approvals, and all team members — including the physician — must fulfill their role. As the adage goes, "If you didn't document it, it wasn't done."

"The most important factor in avoiding denials is to put the patient in the correct status. Then it is crucial that the documentation supports that status," advises **Erica E. Remer**, MD, FACEP, CCDS, an expert in clinical documentation. In describing the patient's status, the physician must "tell the story, and tell the truth."

"The physician needs to detail severity, acuity, include relevant comorbidities, and specify linkage — sepsis due to aspiration pneumonia with acute hypoxic respiratory failure and metabolic encephalopathy," Remer explains. "Not only does it change the coding but it explains your thought process and actions taken."

Remer also advises physicians to integrate Interqual or MCG terminology (such as "hemodynamic instability" or "intractable pain") into their documentation, but remember those are meant to be guidelines for non-providers to judge quality of medical care, not clinical criteria. "Don't exaggerate how sick the patient is; just make sure your words are appropriate for the picture you've painted." ■

Helping Patients Find Motivation to Make Changes

Eat healthy, exercise regularly, and sleep more are healthy goals case managers and nurses reinforce to patients. But case managers often have difficulty living up to their own advice when hectic daily schedules leave little time for healthy pursuits.

These goals are so hard to pursue because the benefits are so long-term. "It's too abstract, too long a time horizon, which is what makes the task so difficult to pursue," says **Michael Slepian**, PhD, assistant professor in the management division at Columbia University Business School.

Slepian is a social scientist whose research typically applies to business management concepts, but he believes there are strong applications to health behaviors as well.

Retirement savings is a long-term pursuit with a long-term goal, similar to health behavior, he explains. However, there is a critical difference. "When you're saving money, you set aside money from a paycheck, and immediately the account goes up," says Slepian. "It's not the same with healthy eating and exercise. You go for a run one day, eat healthy one day,

don't drink alcohol one day, but that doesn't mean you will feel better the next day. It's hard to work long-term on something when the benefits are so far away."

The crux of the problem is that people do not have a solid connection with their future selves, explains Slepian. If they did, people could imagine their healthy future selves — which would be a major source of motivation. "The more connected you feel to your future self, the more you're willing to put in the work now because you feel connected to that future person," he says.

To test the theory, Slepian and colleagues conducted two studies, published in the *Journal of Experimental Psychology: Applied*. In the first study, they assessed how connected 200 participants felt to their future selves. Participants answered survey questions about whether they liked and cared for that future self.

Next, participants reported their health by responding to 10 items assessing physical and mental health, including "In general, would you say your quality of life is…" and "In general, how would you rate your satisfaction with your social activities and relationships?"

Researchers found that those who could visualize and relate to their future selves felt a stronger connection to that person. They also tended to live healthier lifestyles.

But that raised several questions, Slepian explains. Does feeling healthier lead a person to feel more connected to his or her future self? Will this increase optimism and self-esteem? Also, do people with an unhealthy lifestyle feel less connected to future selves? What can be done to improve that outlook?

In the second study, his research group recruited 535 students. Each was asked to write a letter to their future selves. For the longer-term view, they were asked to take five minutes to write a 200- to 300-word letter to their future selves in 20 years. For the near-term view, they were asked to write a letter to themselves three months into the future.

The instructions read: "Think about who you will be 20 years from now [or three months from now] and write about the person you are now, which topics are important and dear to you, and how you see your life."

After submitting their letters, participants pursued exercise plans. Each recorded the length of time they exercised every day. One group was assigned to exercise for 10 days. another group for just two days.

Researchers found that students with a stronger connection between their present and future selves tended to show healthier behaviors and better health. Those without a strong connection engaged in less healthy behaviors. *(The study is available at: https://bit.ly/2YfIMk8.)*

"Healthy behaviors in particular can be hard to commit to, given the very large time spans required to realize their benefits," the researchers noted.

Slepian recognizes this dilemma in everyday life. "When we attend one exercise class, we don't see immediate results in weight loss. We don't see improved fitness today, nor even in the near future," Slepian says. "Conversely, forgoing a healthy behavior today does not hurt health immediately. By taking just a few minutes to visualize your future self — and see yourself benefiting from those healthy habits — you could go a long way in finding motivation."

Case managers can use this same technique to prompt patients in viewing their own efforts, he explains. By simply asking patients to visualize their future selves, even write a letter to that person, it is possible to help them find the motivation to make lifestyle changes.

Writing a letter is one way to think deeply about who that future person is, explains Slepian. When people heighten the connection between the current self and the future self, they help to limit the tendency toward short-term thinking and promote an understanding of how each action — especial those that are concrete and feasible in nature — fits into the "bigger picture."

"Highlight the connection between you today and that person down the road," he advises. "The more you recognize who that

person is, you begin to highlight the connection, and that highlights that it's worth it. The effort is worth it. It's no longer just an abstract concept. You feel a real connection to that person."

It takes just a few minutes to write this type of letter, Slepian says. "Busy professionals as well as patients can take a moment to think about the decisions you make today and how they will affect you down the road."

Putting in the extra work after a hard day will pay off and it will be more obvious in the future, he adds. "This is a message every healthcare professional can apply to their own lives and take to their patients." ■

Nursing Innovation Is Underused and Can Be Leveraged for Career Advancement

Nurses are gaining more stature as potential leaders in healthcare, and much of the innovation in healthcare will come from nurses in the future, says **Antonia M. Villarruel**, PhD, RN, FAAN, professor and Margaret Bond Simon Dean of Nursing, senior fellow at the Leonard Davis Institute of Health Economics at the University of Pennsylvania School of Nursing.

Hospitals should work to leverage the innovative potential of nurses, and nurses in the quality field should look for opportunities to advance their careers through this increasingly available pathway, Villarruel says.

"Nurses have a role to play, and we have the expertise. When you're thinking of quality assurance and quality improvement, nurses can have a significant influence," she says. "Nurses' roles at the patient level get recognized, but we need to be elevated to leadership at the level where system changes can happen. Quality improvement is where people look to make system-level changes, and organizations should look to involve nurse leaders in those efforts."

A recent report from BDO and the University of Pennsylvania School of Nursing addresses how clinical and industry leaders are leveraging nurse innovation. BDO provides this summary of the findings:

• "Nursing innovation has yet to be fully unleashed, including institutionally, regulatorywise, and policywise." BDO says only 46% of business leaders report their C-suite includes a representative with a nursing background. Less than one-third say they have a nursing leader whose primary responsibility is innovation.

• "Nurses will gain a seat at the leadership table." Having nurse innovators in advanced leadership by 2025 is considered very important by 57% of leaders, and 81% say it is very important to have nurses as decision-makers on strategic planning teams.

• "Unleashing nurse-led innovation will create positive ROI." Nurses will play a critical role in transforming care by 2025, BDO says. They will have the most opportunity to influence care in chronic care management, mental health, and population health.

(The report is available online at: https://bit.ly/317fQh5.)

The survey results indicate that healthcare leaders are recognizing the value of innovative nurse leaders, but their organizations have not yet fully installed them in leadership positions, says **Karen Meador**, MD, managing director of the BDO Center for Healthcare Excellence & Innovation in New York City.

"There is an opportunity for more of these institutions to put nurses in these innovator leadership roles. It may not necessarily have the title 'innovation' in it, but any healthcare leader needs to be innovating on an ongoing basis," Meador says.

"Only 7% of CEOs are nurses, and if there is a chief innovation officer, only 8% are nurses. Not having a nurse in an innovative leadership position means they are missing out on the unique perspective that a nurse brings to the table."

Villarruel notes that the survey found the most valuable skills for nurse innovators are design thinking, clinical acumen, and the interface of clinical acumen and technology. Nurses with these skills will be positioned to advance their careers in quality improvement, she says.

"Innovation is needed to keep moving quality improvement to the next level and address the current challenges," Villarruel says. "Healthcare organizations are recognizing that having the right nurses in the leadership roles will be beneficial to the goals of the organization, so innovative nurses with the right skill sets will be in demand."

Meador adds that quality improvement professionals with a nursing background and the desired skill sets should seek recognition and strive for leadership positions.

"A lot of quality improvement professionals are already doing this work and demonstrating these needed skills, but I think it's time to take the covers off and really show what it is you're doing to improve patient quality and safety," Meador says. ■

HOSPITAL CASE MANAGEMENT

CE INSTRUCTIONS

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CE QUESTIONS

1. **Which of the following is a potential benefit of the student health coaching model employed by some hospitals and colleges?**

   a. Students gain valuable experience, patients like the visits, and ED visits decrease.
   b. Health coaching can be an alternative residency program for nursing and medical students.
   c. Case managers can train new case management prospects by working with student health coaches.
   d. It can save a hospital money in staffing costs.

2. **What is the patient activation measure (PAM), developed by Judith H. Hibbard?**

   a. PAM is a series of webinars that patients watch to improve self-care behavior.
   b. PAM provides a framework for case managers to work with primary care providers on motivational strategies.
   c. PAM is based on the theory that there is a great deal of variation in patient activation/engagement in a patient population.
   d. PAM is an electronic tool that prompts patients to make the right decisions when they open the refrigerator door or are not moving enough.

3. **Which of the following is the most important factor in avoiding denials, according to Erica Remer, MD, FACEP, CCDS?**

   a. Clearly explaining the patient's status to the payer
   b. Establishing procedures for a peer-to-peer review
   c. Putting the patient in the correct status
   d. Communicating with colleagues

4. **According to Michael Slepian, PhD, which of the following is a health benefit of connecting to one's future self?**

   a. Motivation to pursue long-term health goals
   b. Thinking positive thoughts to reach long-term goals
   c. Increasing self-awareness to improve mental health
   d. Reduce stress by imagining future goals

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

Case Management's Role in Managing Denials and Appeals in the New Healthcare Environment

By Toni Cesta, PhD, RN, FAAN

Introduction

Revenue is defined as the sum earned by the provider, measured in dollars. The revenue cycle is defined as the series of activities connecting the services rendered by a healthcare provider with the methods by which the provider receives compensation for those services. Case management plays an integral role in managing revenue and the revenue cycle in the denials and appeals processes. This month, we will discuss the case manager's role in the revenue cycle as it relates to the management of denials and appeals.

CASE MANAGEMENT PLAYS AN INTEGRAL ROLE IN MANAGING REVENUE AND THE REVENUE CYCLE IN THE DENIALS AND APPEALS PROCESSES.

Start With Medical Necessity

As case managers, we must ensure that our patients meet medical necessity as it relates to care. Your role in utilization management supports the revenue cycle by determining medical necessity prospectively, concurrently, and retrospectively. The American College of Medical Quality defines medical necessity as the accepted healthcare services and supplies provided by healthcare entities.[1] These services must be appropriate to the evaluation and treatment of a disease, condition, illness, or injury, and must be consistent with the applicable standard of care.

Key Functions of Denial Management

Case managers should ensure that the clinical information available in the medical record is accurate and reflects the care rendered to the patient. To ensure accuracy, you should work with your clinical documentation specialists to confirm that they are aware of any deficits in the documentation. You also must ensure that this information is provided, when necessary, to a third-party payer in a timely manner and based on nationally established guidelines. Per the CMS Conditions of Participation for Utilization Review, each hospital may choose the criteria they would like to follow when conducting clinical reviews. A hospital can use different criteria for different payers. Finally, we must ensure that the patient transitions to the next level of care as quickly as possible once he or she no longer meets the clinical criteria for the current level of care.

In terms of clinical reviews, we prevent denials by performing one of the following three types of reviews:

- **Prospective Review:** Occurs before care is rendered;
- **Concurrent Review:** Occurs while services are rendered;
- **Retrospective Review:** Occurs after services have been rendered.

During the concurrent review process, the third-party payer's case manager will approve or deny payment for the hospital stay, or a portion of the hospital stay. You most likely will be informed of this information during the review, or by an "end of day" report, or via mail.

Once a denial occurs, an appeal should take place. As per the hospital's contracts, as well as the insurance and public health laws, there are time limits to this process. You generally have between 30 and 60 days to appeal a denial of payment. The insurance company must respond to your appeal within similar parameters. An appeal may result in confirmation of the entire denial, denial of a portion of the stay, or complete reversal of the denial. As

an acute care case manager, you may be directly involved in the written formulation of an appeal. This function may be performed by the admitting physician or by designated nurses in the case management or finance departments.

To prevent denials, the best defense is always a good offense. Ultimately, the goal is to prevent denials. This improves the revenue cycle and reduces the amount of paperwork needed to appeal to a third-party payer.

Reasons for Third-Party Payer Denials

Each organization may categorize its denials in various ways. Categories generally fall into either clinical or nonclinical groupings. Clinical denials are related to the patient's condition and are decided based on the appropriateness and medical necessity of the clinical care delivered. An example might be a denial of reimbursement for a diagnostic or therapeutic procedure, such as endoscopy that is not justified or precertified as an inpatient procedure. The nonclinical reasons include those that are unrelated to the patient's clinical situation or need for care. They usually indicate factors in the organization's contracts that were not met, such as delays in submitting claims.

Nonclinical (Administrative) Reasons for Denials

• Technical: Medical record not produced by requested deadline.

• Appropriateness of setting: Procedures that should be performed in outpatient setting (e.g., ambulatory surgery, ED). These cases can be billed to these settings.

• Delay in service/treatment: Primarily on weekends when patients are waiting for tests.

• Initial noncovered services: Services usually not covered by payer (e.g., cosmetic surgery, dental care for Medicare fee-for-service [FFS] patients).

• Pre-certification: No prior authorization from third-party payer. Emergency admissions require notification to payer within 24 hours.

• Code 44: Admission downgraded to observation or outpatient.

• DRG: Payment for a different DRG than originally billed.

• Untimely billing: Bill submitted more than 60 days after discharge.

• Hospital-Issued Notice of Noncoverage (HINN) issued incorrectly: HINN letter given to Medicare patients when services are no longer covered by Medicare (e.g., custodial care or awaiting home care). PRO decides if the patient is still covered by Medicare.

• Preoperative days: All elective cases should be admitted on the day of surgery/procedure.

• Pass day: When a patient is discharged and later readmitted for treatment of the same medical condition within 60 days, hospitals should bill the two admissions as one (e.g., the patient was either admitted with or develops an infection that must be resolved before surgery).

• Payment inconsistent with service: Payment is determined contractually (i.e., case rate, HIV, or psychiatric per diem rate, when such contractual billing agreements are not followed).

• Two-Midnight Rule: Rules and documentation incomplete and noncompliant with this rule.

Clinical Reasons for Denials

• Continued stay: Patient no longer meets acute care criteria.

• Medical necessity on admission: Admissions and treatments that do not meet inpatient care criteria.

• Necessity of procedure: No documentation to support the need for the surgical procedure.

• Premature discharge: Patient readmitted within 31 days. The CMS Quality Improvement Organization denies second admission if they decide the patient was discharged prematurely on first admission.

• Alternate level of care: Patient no longer meets acute care criteria but could not be discharged without continued services (e.g., nursing home, home care).

• Level of care reduction: Payer decreases payment to subacute rate for inability to meet acute care criteria.

Appealing Nonclinical Denials

Nonclinical denials are much more difficult to appeal. Because the denial is based on the contract with that insurance company, the basis of an appeal may be rather limited. Your department must decide whether it will take the time to appeal. One must weigh the odds of winning such an appeal against the cost of generating the appeal. It is very difficult and rare to win nonclinical appeals.

Appealing Clinical Denials

The case manager, or other person writing the appeal, should review the case against the established review criteria. When possible, the criteria should frame the argument for the appeal. It should refer directly to how the patient met the criteria. These criteria will form the greatest likelihood of a reversal. If the criteria are not met, the appeal may be much more difficult to win. Other arguments may need to be

introduced, such as the unavailability of subacute care beds or home care services. These arguments generally do not win an appeal. The case manager in the acute care setting needs to know the philosophy of the organization to know whether there is an expectation that such appeals will be written. Once again, the likelihood of winning such an appeal must be weighed against the cost of the labor spent on writing it when those resources might be better spent on writing an appeal with a greater likelihood of success.

When Can Denials Occur?

To prevent denials, you must be aware of where they most commonly occur. Be aware of these situations so that you can prevent a denial whenever possible.

The admission assessment should be completed on the day of admission to ensure the correct level of care from the beginning of the stay. The patient then should then be reassessed each day of the hospitalization. During this process, be sure that the correct level of care has been selected by the admitting physician and that the documentation supports it.

During the admission process, ask these questions:

- Is this patient sick enough to be in the hospital?
- Is this patient receiving care at a level requiring admission?
- If the patient is on Medicare, will he or she be in the hospital for at least two midnights?

Denials also can happen for any of the following reasons:

- Inaccurate payer information entered during the registration process;
- Inpatient-only procedure, but patient not placed in inpatient status;
- Physician is not asked to supplement documentation before a Code 44 process is initiated;
- Physician advisor is not included in the Code 44 process.

These reasons all must be monitored by the case manager.

Continued Stay Process

Many things can occur during the inpatient stay that can result in a denial of payment. Clinical reviews must be sent to the payer as requested. If your managed care contracts have a cut-off time for submission of reviews, a late review also can result in a denial.

Delays in care can trigger a denial if the patient is not receiving an acute level of care each day, called "carve-outs."

During the hospital stay, be sure that you collaborate and communicate with the patient's physician of record as well as the interdisciplinary care team. Lack of collaboration and communication can result in delays in care that can trigger denials.

Ask the following questions during the continued stay process:

- Is this patient receiving care at a level that requires the patient to continue to stay in the hospital?
- Is the patient responding to treatment?
- Does the documentation in the medical record support medical necessity?

Discharge Process

During the discharge process, consider whether the patient meets medical necessity for movement to a lower level of care. Delays — and, therefore, denials — can occur if you do not begin the discharge planning process as early in the stay as possible.

In addition to performing an early assessment, you also should develop a professional relationship with the patient and family, if available. Discussing the discharge process early in the stay will help prevent delays and/or denials as the patient progresses toward discharge.

Government Contractors

Case managers must manage more than just third-party payers, commercial denials, and appeals. CMS has implemented a variety of initiatives to prevent improper payments by identifying and addressing coverage and billing errors by employing contractors to process and review claims using the Medicare rules and regulations. In many hospitals and health systems, outside vendors complete the appeals for these denials. In any case, it is important to be familiar with the names of the most common contractors currently working with CMS.

Medicare Contract Reviewers

- Medicare Administrative Contractors (MACs): Process claims submitted by physicians, hospitals, and other healthcare professionals. Submit payment to those providers following the Medicare rules and regulations, including the identification of underpayments and overpayments;
- Zone Program Integrity Contractors: Identify cases of suspected fraud and take corrective actions;
- Supplemental Medical Review Contractors: Conduct nationwide

medical reviews, including underpayments and overpayments;

• Comprehensive Error Rate Testing Contractors: Collect documentation and perform reviews on a random sample of records of Medicare FFS claims and produce an annual improper error rate;

• Recovery Auditors: Identify under- and overpayments as part of the Recovery Audit Program.

Prepayment and Post-Payment Reviews

Some Medicare claims reviewers perform post-payment reviews using samples of records that are selected using statistically valid sampling processes. The sample allows the reviewer to estimate underpayments or overpayments without reviewing all records of the provider in question.

The MAC also may place providers on prepayment reviews. This typically occurs when a provider is identified as having a disproportionately high error rate. In the prepayments process, a percentage of claims will go through prepayment review. This delays the rate at which the provider will be paid for claims, and negatively affects the revenue cycle. The process continues in a specific facility until the MAC deems that the billing practice has been corrected.

The Recovery Audit Program reviews past Medicare fee-for-service claims for potential over- or underpayment. The auditors use the Medicare rules and regulations, including national and local coverage determinations, billing instructions, and other coverage provisions. They analyze claims data using software that identifies claims that may contain over- or underpayments and request the records accordingly.

Providers must respond to an auditor's request for medical records within 45 days of receiving the request or be subject to a denial. The provider has the right to appeal these and other other Medicare program overpayment denials.

Methods for Reducing Denials

The following list describes some concrete ways in which one can work toward reducing denial rates:

• Employ a gatekeeper at each entrance point in the hospital;

• Give feedback to case managers regarding denials;

• Meet with payers regularly to work out issues;

• Ensure physician processes are sound;

• Provide accurate and appropriate documentation;

• Use escalation process to attending and/or physician advisor;

• Create effective physician advisor role;

• Ensure excellent documentation;

• Employ knowledgable staff;

• Train case managers and social workers;

• Use a strong medical record for case management process;

• Include utilization management notes (not in medical record);

• Use strong interdisciplinary processes;

• Employ interdisciplinary care rounds;

• Implement walking rounds;

• Ensure the hospitalist and other physicians actively involved;

• Track avoidable delays;

• Hardwire concurrent appeal process;

• Monitor the effectiveness of your physician advisor;

• Review records to ensure admission status is correct;

• Share denial and appeal data with the utilization management committee monthly;

• Maintain case manager competencies;

• Develop a denial dashboard.

Summary

The best way for any case management department to reduce its denial rate is to prevent denials. Take a look at your own processes and be sure to hardwire them whenever possible. ■

REFERENCE

1. Definition and Application of Medical Necessity, American College of Medical Quality, 1995,5(1):6.