HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

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INSIDE

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Hospital-SNF Partnership Brings Better Care for Complex Patients

By Melinda Young

An ongoing problem that was made much worse during the COVID-19 pandemic was coordinating post-acute services for patients.

Sometimes, case managers struggled to match patients' apparent needs with what their insurer or Medicare would pay. When the pandemic hit, many providers stopped accepting patients, reduced available bed space, or would turn away patients who had recovered from COVID-19. This problem led to people going home or to post-acute care without access to services they needed.

> VULNERABLE, COMPLEX PATIENTS NEED SERVICES AFTER THEY ARE DISCHARGED FROM THE HOSPITAL, BUT TRANSITIONS CAN BE CHALLENGING.

For example, patients with continuing acute needs might be best served in a long-term acute care (LTAC) facility, but they might not receive Medicare reimbursement if patients did not meet the requirements for transition from an intensive care unit (ICU), says **Jenn Leitch**, MN, RN, CCM, CGS, nurse manager in the department of care management at Oregon Health & Science University (OHSU).

Since the Centers for Medicare & Medicaid Services (CMS) revised its hospital inpatient prospective payment system (IPPS) for acute care and long-term care hospitals in 2015, transitioning patients to LTACs has been more challenging.

"We saw a decline in the number of patients we could send over there,"

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Leitch says. "We're sending half the patients over there that we were."

Complex Patients Need Post-Discharge Services

Vulnerable, complex patients need services after they are discharged from the hospital, but transitions can be challenging. One potential tactic is a partnership with a local skilled nursing facility (SNF), Leitch says. Such a partnership can help the SNF care for high-need patients who were denied care at other post-acute levels.

"This [partnership] has been very successful," Leitch says. "We saved 2,382 hospital days over the fiscal year of July 2019 to June 2020 because we transitioned these patients to skilled nursing facilities sooner."

Leitch recalls a case that involved a patient who was homeless and not ambulatory. The patient had no insurance when admitted to the hospital.

"We got the patient on Medicaid, but the patient was denied admission at every skilled nursing facility because of the person's homelessness, possible substance use disorder, and behavioral issues," Leitch explains.

The patient was transitioned to the special SNF program, received rehabilitation, and began to walk again — all within the 20-day stay. "We helped advocate for adult foster home funding and discharged the patient from the SNF to home health and physical therapy," Leitch says.

The hospital-SNF collaboration can handle patients with complex needs and some social determinants of health issues, but not cases in which the patient poses a danger to staff, such as patients who are placed in restraints due to risk of violence, she adds.

Executive leaders meet weekly with SNF leadership. "We help support the local SNF in complex problem-solving and care coordination," Leitch says.

Leadership teams developed criteria to identify patients who would benefit from the transition. "The first criterion is that patients have been denied to other skilled nursing facilities," she says. "There typically are a lot of reasons why people were denied. When we worked with the SNF, we created a list of patients they could provide specialized clinical care pathways for. They put a lot of effort into education of their nursing staff to make sure they could care for complex wound patients, patients needing IV antibiotics, and patients needing trach care, and who had diabetes, strokes, traumatic brain injury, cognitive weakness, dialysis,

EXECUTIVE SUMMARY

Coordinating post-acute services for patients has been an ongoing challenge during the COVID-19 pandemic.

- One solution is for hospitals to form partnerships with local skilled nursing facilities.
- Partnerships with post-acute organizations can help hospitals find adequate care for complex patients.
- Hospital case managers and other staff can help the skilled nursing facility with difficult problem-solving and care coordination.

and substance use disorder." If needed, SNF staff could collaborate with the hospital's addiction specialist.

The program begins with a structured escalation process at OHSU. Case managers escalate any patient with a barrier at discharge. The case goes to the leadership team to determine if the patient is eligible for the transition to the collaborating SNF. Once a patient is approved for the transition, a SNF liaison works with the case manager, who talks to the patient and explains transition options.

"The program discharges the patient from OHSU. We help the patient's progression at the SNF, and then help the SNF discharge the patient from there," Leitch says.

When patients transition to the SNF, case managers and other providers review patients' progress and rehabilitation goals. "We go over how they're doing with nursing and social services," Leitch says. "We give advice and guidance on how to navigate social services and the community, and how to work with patients, families, and with community partners."

After leaving the SNF, the patient may need services from adult foster home placement agencies, residential care placement agencies, or home health agencies.

"That's why the program has been so successful," Leitch says. "Skilled nursing facilities shy away from a lot of vulnerable and complex patients because they don't have the staff education, support, and resources to manage complex discharge plans."

But with the hospital case management and additional help throughout the patient's stay, the SNF can provide quality care to these patients.

"The skilled nursing facility is managing the case, but our leadership team and post-acute care coordinator help," she says. "We're more like consultants who support them, and we build relationships, identifying barriers. The number of patients in the program fluctuates, depending on the need. We've had as many as 13 patients in the program, and these require highly complex care coordination with Medicaid, disability, and community agencies. We've had as few as five or six." ■

Discharge Algorithm Improves Transitions, Results

By Melinda Young

Hospital case managers can leverage decision support technology to improve transitions of care and the discharge process.

Case managers know where to find information about patients' comorbidities, caregiver support, admissions history, and other factors that affect discharge. But this information may be scattered throughout the patient's chart, or is unknown, says **Kathryn H. Bowles**, PhD, RN, FAAN, FACMI, professor of nursing and van Ameringen chair in nursing excellence at the University of Pennsylvania School of Nursing. An algorithm that works within an electronic health record (EHR) can find the necessary information and allow case managers to access it quickly and efficiently.

For instance, the Discharge Referral Expert System for Care Transitions (DIRECT) algorithm can help case managers and clinicians regarding post-acute care referrals and level of care.[1] "DIRECT puts it all in one place for them and gives them the gestalt of the patient," Bowles says.

Case managers can get a feel for what is needed for an optimal discharge. But without a technological tool to provide the needed information in one place, case managers might not be able to synthesize the data as efficiently. With the support, they can quickly know the patient's function has declined over the hospital stay, and they will know the caregiver status.

Decision Support

In research and development of DIRECT, the electronic record ran the algorithm 24 hours after patients were admitted to the hospital. Case managers could receive the decision support several times a day, if desired. It produces a spreadsheet that characterizes patients in terms of whether they will need post-acute care. It also recommends the level of care, home care, or facility.

"It gives case managers an early heads-up that this is a patient they should consider for post-acute services, based on the patient's characteristics," Bowles explains

These are the most common characteristics included in the algorithm:

- Functional status;
- Cognition;
- Caregiver status;
- Admissions history;
- Comorbid conditions;
- Access to the house and condition of the house.

The decision support tool makes a case manager's job easier, but developing and integrating the technology is more challenging. Bowles worked on developing the tool for years and has researched the use of DIRECT and an earlier version of the algorithm.

Bowles and co-investigators built and validated an expert clinical decision support system for discharge referral decisions about post-acute care. They published a study that showed highly satisfactory predictive summary statistics on the algorithm. The authors suggested evidence-based decision-support tools for discharge planning can alleviate workloads for discharge planners.[2]

Researchers studied patients taking multiple medications and histories of previous conditions. Their likelihood of readmission was high. "You would expect that people who are at high risk of readmissions would come out of acute care and receive skilled nursing facility services, or something else to further their recovery," she explains. "The majority of the patients went home to self-care."

The investigators asked advanced practice nurses to study these cases and determine if they would refer these patients to post-acute services. The nurses said they would have referred all but a couple of the patients to post-acute care.

"We looked at those patients who didn't get services, and 49% of them were readmitted within 12 weeks," Bowles says.

Among patients who went home without services, those who were flagged as needing services were readmitted at a rate of 5% higher than those who were not flagged by the algorithm.[3]

Case management and care transition guidelines and best practice models also are useful tools. But these lack the dynamic flexibility of an electronic decision support tool that can be adapted to individual hospitals and units. "The elements within the algorithm need to be pulled from the databases of hospitals," Bowles says.

The first-generation discharge algorithm that preceded DIRECT was built into software and used by dozens of hospitals, she adds.

Partner with IT

The integration process for this tool works more smoothly with a hospital champion. "Case managers are key people to say, 'We really want this and want to have better outcomes for our patients,'" Bowles says.

Once hospitals decide to use a decision support tool, case managers can partner with information technology (IT) staff to decide what information to collect and how to collect it. Case managers explain the data they need to determine patients' functional status, and IT professionals explain how the databases work and how things are collected in the electronic record.

One thing to keep in mind is that while the algorithm suggests which patients would benefit from certain post-acute services, physicians and patients might disagree and choose other options.

"The algorithm identifies people who needed services and didn't get them, and people who did not need the services and did get them," Bowles says. "We haven't studied why this happened, but one reason why the algorithm identifies people who don't get the services is because of patient refusals."

For example, the authors of another study performed a chart review of patients who refused post-acute services. They found the most frequent reason for refusal listed by men was their spouse would be the caregiver.[3]

Other reasons for refusals of services include:

- Patients do not want someone in their home.
- Patients do not carry enough insurance coverage for the service or cannot afford the copay.

"We built our algorithm using expert clinicians, doctors, nurses, social workers, and physical therapists who evaluated case studies," Bowles explains. "We had almost 1,500 case studies of actual, hospitalized patients, and we had them review these cases and tell us what they would do and whether they would refer them or not for post-acute services."

EXECUTIVE SUMMARY

Decision support technology can help case managers improve transitions of care and more easily access patient information necessary for an optimal discharge.

- The algorithm can collect data on patients' functional status, cognition, caregiver status, and other important characteristics.
- Advanced practice nurses helped develop the algorithm by studying cases to determine if they would refer these patients to post-acute services.
- Case managers can partner with information technology staff to implement the electronic decision support tool.

The algorithm was built on clinical need and expert opinion, and did not consider barriers such as homebound status or insurance, Bowles says.

After integrating the decision support tool in the EHR, case managers need instruction on how to use the tool. Optimally, they were involved in the integration process and were familiar with and supportive of the tool.

"We educated case managers about the algorithm, how we developed it, how it worked," Bowles explains. "We find out how they want to receive the information, which information they want, and where in their workflow they could review it."

Then, the program sent case managers a spreadsheet, twice daily, of their patients and algorithm advice.

Investigators found the patients who refused the services were twice as likely to be readmitted within both 30 days and 60 days, compared with those who accepted the referral.[3]

The reports can be sent to case managers at any time and as many times a day as desired. Using the information, case managers can help patients and their families prepare for a post-acute referral by introducing the idea that the patient may be sent to a skilled nursing facility or need home health services after leaving the hospital, Bowles says. ■

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Care Transition Program Shows Success with Long-Term Outcomes

By Melinda Young

A program designed to prevent hospital readmissions and ensure best practices in transitions showed early positive outcomes and has continued to demonstrate improvements over the past eight years.

"Key indicators of readmission rates and emergency department utilization continue to decrease, and our performance improvement activities focus on this continued reduction," says **Janet Kasoff**, EdD, RN, NEA-BC, senior director of care management learning and innovation with Montefiore Care Management Organization in Bronx, NY.

The program's goals and objectives have remained the same, including the goal of reducing 30-day unplanned readmissions associated with poor transitions of care, and improving the patient experience by identifying and responding to patients' concerns immediately during the post-discharge period — before receiving the patient satisfaction survey, she notes.

The hospital's Care Transitions Clinical Coordinators (CTCCs) program gives patients and their caregivers support while preparing to move from the acute inpatient setting. "We hand off patients discharged from the hospital to the post-discharge care transitions program," Kasoff explains. "It is not the same RN who follows the patient in the hospital and into 60-days post-discharge, as we did with the [2013] research study."

The hospital CTCC focuses on these key interventions:

- Assessment and identification of the root cause of readmission;
- Working collaboratively with the interdisciplinary team to develop the plan of care;
- Teach-back for patient education provided by the unit staff;
- Ensuring documentation of the transitional care plan in the electronic health record;
- Post-discharge appointment scheduling;
- Health home referrals;
- Making referrals to community-based organizations;
- Closing the loop on referrals to ensure appointments are made and kept;
- Sharing information with

providers receiving the patient in the community.

The information is shared via warm handoffs with providers when feasible. The care transitions team follows up with patients after discharge, Kasoff says.

The transitions team calls patients and caregivers to offer support during the move home. These are some of the key interventions of the care team:

- Call within 48-72 hours after discharge;
- Conduct transition of care screening to identify red flags, such as new or worsening symptoms, condition-specific indicators, self-management knowledge deficits, signs and symptoms of depression, and understanding the role of the primary care provider;
- Perform medication reconciliation and assess medication self-management, including patient compliance to prescribed medication regimen and addressing medication problems due to financial issues or lack of access;
- Post-discharge follow-up with primary care providers and specialists;
- Evaluate psychosocial issues, including cognitive and functional deficits, caregiver gaps, and use of personal health record;
- Determine eligibility for referral to complex care management, condition-specific management, behavioral health management, the House Call Program, pharmacy management, and applicable community resources and linkages;
- Perform patient satisfaction screening to help mitigate negative factors affecting the patient experience of care and patient satisfaction outcomes.

Telehealth Contributes to Growth

Over time, the program has evolved with more use of telehealth services. "Technology has evolved and afforded us the opportunity to do telehealth visits with patients for care management follow-up and to schedule video visits for patients with their provider," Kasoff says. "We can see what is going on in the home in real time. This allows us to observe the client, which is especially important during patient education teach-back sessions."

The advantages of telehealth have contributed to the program's continued success.

"The implementation of telehealth visits has improved the ability for patients to keep their appointments post-discharge," Kasoff says. "The care managers track if an appointment is made post-discharge, and whether the appointment with a provider was kept. If the appointment was not kept, the care manager RN reaches out to the patient and schedules another visit."

Other Technological Changes

Another technological advantage: The implementation and integration of care management documentation in the longitudinal electronic health record affects the provider/care manager and communication.

"This effectuates our ability to perform our care management and care coordination functions more effectively," she says. "The implementation of the electronic personal health record capability also has improved the communication with the patient and their provider. The patient's real-time access to key clinical and nonclinical data in one repository makes managing their transitional care more organized, effective, and collaborative."

Program leaders plan to leverage technology further and establish a remote patient monitoring program for patients with hypertension or diabetes.

Patient education is crucial to any care transition success, but providing it within the hospital setting is difficult. "The short length of stay and acute stay care nature of the hospitalization makes it challenging for a patient to learn new skills and information," Kasoff says. "Therefore, post-acute follow-up is extremely important."

The timing of the education also

EXECUTIVE SUMMARY

A hospital's Care Transitions Clinical Coordinators program provides patients and caregivers with care transition support.

- The program focuses on assessment and identification of the root cause of readmission, as well as other key interventions.
- One important feature is the post-discharge call, which is placed within 48-72 hours of discharge.
- The program focuses on patient education with repetition and validation the patient understands the medications. Also, a medication reconciliation is provided post-discharge.

is very important. "People may be anxious or overwhelmed, which make it a challenge to learn new information and skills," she adds. "Repetition and teach-backs are very important for these reasons."

Patient education also should be demonstrated. "Repetition and validation that the patient understands the medications and performs an effective medication reconciliation post-discharge is very important," Kasoff says. "Also, patients must be engaged in their care."

Patients should agree on their self-management goals and be active members in the care plan. "Patient education to empower patients and caregivers fosters patient engagement," Kasoff adds. ■

Occupational Therapy and Hospital Readmissions

By Jeni Miller

Occupational therapy (OT) is a bit like case management. In both vocations, the greater healthcare community (and population in general) is not entirely familiar with their purpose. Both positions often are all-encompassing, diverse, and necessary as they consider the whole person. Both occupational therapists and case managers often play a role in helping control hospital spending.

The authors of a study noted "occupational therapy is the only spending category where additional hospital spending has a statistically significant association with lower readmission rates" for certain health conditions.[1] This seems to be a significant fact to which case managers should take notice.

"In a hospital setting, everyone is looking toward where this person is going next and asking what would an appropriate discharge be? Occupational therapy practitioners look at this through several lenses: cognitive, physical, social supports — just the whole person," says **Heather Parsons**, MSOT, vice president of federal affairs for the American Occupational Therapy Association. "We try to identify things that could otherwise go overlooked, and plan strategies and supports for the best discharge. This can help prevent readmissions."

Colleen O'Rourke, senior vice president of clinical and network solutions at naviHealth, sees occupational therapy as vital to a successful and more permanent hospital discharge.

> "THERE ARE PLENTY OF STUDIES THAT SHOW THAT WHEN A PATIENT TRANSITIONS TO THEIR OWN ENVIRONMENT, THEY REPORT A MORE COMFORTABLE AND FASTER RECOVERY."

Occupational therapy can address functional issues that might allow a patient to bypass a skilled nursing facility (SNF) stay and transition directly home. "The literature tells us that when a patient is able to recover at home, they are less likely to fall, get an infection, and experience depression," O'Rourke explains. "There are plenty of studies that show that when a patient transitions to their own environment, their quality of life score is much higher, and they report a more comfortable and faster recovery."

But how can one discipline make such a difference? "OTs are the experts when it comes to activities of daily living [ADLs]," O'Rourke says. "They take a holistic and pragmatic approach to maximize a patient's independence in skills like cooking, eating, and dressing. For instance, think about medication management. I am not talking about medication education or administration, but specifically management. Mismanagement of medications is one of the main reasons for hospital readmissions. Occupational therapists look at the unique patient, including social determinants of health, and help to make a specific medication management plan."

O'Rourke emphasizes how OTs often ask different and detailed questions, and then go to work considering all the opportunities that result.

"What is the plan to fill the prescription?" she asks. "What happens when you run out? Where will the meds be stored? If stored in the cabinet, the patient may not remember to take it. If it is stored in a humid bathroom, the medication

might lose its effectiveness. Does the patient have enough grip strength to open a childproof cap? The dexterity to remove a single pill? What if there is cotton in the bottle? What do you do if a pill falls on the floor? OTs think about all of these complexities."

When OTs Intervene

OTs consider two main facets when determining next steps for a patient and their transition of care: cognition and home environment.

"With cognition, it's not just their orientation to time and place, but asking whether this person has the cognitive skills to take care of themselves and function at home," notes Parsons. "After assessing, an OT may make a recommendation, 'I don't think this person is safe at home,' or make recommendations for additional supports they will need. We also ask whether their home environment itself will support the person being there safely. Even if they are given education at discharge, they may not always be able to follow those instructions if the environment doesn't support them. Occupational therapy will ask: Are they at risk for a fall? Do they have an appropriate support person at home? With their medication plan, we don't get involved in what the medications they take, but we think about whether they can open the bottle and remember when to take it."

O'Rourke echoes these statements, adding the OT role is "so incredibly functionally based and detail-oriented when it comes to the overall functioning of the individual."

"OTs are the unsung heroes for seniors especially, because they're experts in daily living," O'Rourke shares. "They can be very effective in the hospital setting, but unfortunately, what's evolved over time is that therapists generally consulted toward the end of a patient's stay and are asked a single, binary question: Can the patient go home, or do they need to go to a rehab setting? This, unfortunately, is an underutilization of their talent and skill."

When OTs are brought in to help patients as soon as possible, they can help combat the likely debility that develops because of the hospitalization. This can be an investment that keeps hospital spending low.

Speaking of Spending

Researchers have noted "investing in occupational therapy has the potential to improve care quality without significantly increasing overall hospital spending."[1] This fact should catch the eye of hospital administrators as well as case managers.

"As far as intervention goes, we're pretty cheap," Parsons notes. "We're just not that big of an expenditure. Not only that, but I think about how much we spend on medical care. [Bringing in OT] is not that much more to close the gap for a safe discharge and to set the person up for success long term."

Still, this particular therapy is not as common in hospitals as it perhaps once was.

"Offering OT in hospitals has dwindled significantly," O'Rourke laments. "We should ask, 'What are we not doing from a clinical perspective to help the patient obtain and maintain their highest practical level of function, even while hospitalized?' This is a lost art for hospitals, perhaps because once the patient is stable, the primary focus is discharge. Early mobilization programs, including ambulation, out-of-bed schedules, walking to the bathroom vs. using a bed pan will fight the debilitating effects of bed rest and help more seniors return home. This is where the hospital therapy teams excel. It's the right thing to do."

Case Manager Takeaways

How can hospital case managers best use the expertise of OTs for the benefit of the patient and the hospital?

• **Observe.** Staying alert and asking "why" questions can help case managers think about what might best help their patient.

"What is causing them to fall in their home?" Parsons asks. "I've known some [case managers] who have repeat patients. Asking these questions leads them to send in an OT to figure out what is going on, or order OT upon discharge to address chronic falls or failure to thrive."

"Case managers already have the skills of astute observation," O'Rourke adds. "They're always paying attention to the verbal and nonverbal signs from the patient. If they walk into the room and see that the tray is half-eaten, they may pause and wonder, 'Is it no appetite or inability to feed themselves? Should OT take a look?'"

• **Refer.** Taking that astute observation to the next level, case managers might consider when a referral to OT is appropriate. One piece of advice Parsons shares is to remember to ask the patient about his or her goals of care and function, or bring in an OT who can analyze further and help establish realistic goals for function and discharge.

"We ask the person what they want to do post-discharge," Parsons explains. "How are you going to be in your home, and what are your priorities? The answer to that can change the importance of different skills and discharge recommendations. If someone loves to cook, but can't do that safely, that's an important consideration for education and discharge. But if someone else may just want to microwave a TV dinner and cooking is not important, that changes things"

O'Rourke also suggests hospital case managers consider how they can refer to OT in the hospital to get the ball rolling on things like home modifications and equipment needs, and then refer to OT in the home for follow-up.

"It makes good sense for hospital case management departments to understand the capabilities of rehab departments in the hospital," she says. "They have expertise that is worth tapping into so the case manager does not have to go it alone."

"Patients with congestive heart failure or COPD have the highest readmission rates," O'Rourke continues. "The reason for the hospitalization is medical, but what brought them to the hospital is usually functional. A patient will ignore their shortness of breath until they are too winded to make it to the bathroom in time. Or a patient will disregard the fluid building up in their legs, only to call the doctor when those legs are too heavy to get into bed. It's too late then. OTs can coach patients to recognize symptoms early and seek intervention sooner, possibly avoiding a readmission."

• **Collaborate.** If possible, inviting the OT to the conversation earlier can potentially benefit the patient by bringing in another valuable perspective.

"One key piece is having OT in on patient rounds or other team meetings," Parsons shares. "When staff meets about the patient, often OT is not included in that group. I would give OT the opportunity to collaborate immediately, because their focus is on helping people do what they need to do upon discharge. OT doesn't always fit within the traditional medical model, but it is very person-centered and common sense. What we're doing looks so simple sometimes, but truly we are looking toward maximum independence and safety."

"Get the OT consult in earlier, not just 24 hours before discharge," O'Rourke adds. "This can potentially make the difference."

Reducing readmissions certainly is a worthy goal — and it makes extra OT referrals valuable and wise. They are the perfect partners for hospital case managers, similar in respect to their ability to look at the whole person, consider several different angles of patient care, and wear many hats to finish the job.

"Occupational therapists are ideal coaches because they have a unique skill set," O'Rourke says. "They are innovative, clever, pragmatic problem-solvers focused on maximizing independence in life's daily skills. They look at it from the perspective of a patient's going home successfully and staying home successfully. It's only the OT who will ask a patient, 'How exactly are you going to get the trash to the curb every Wednesday?' Believe it or not, those are the types of problems that cause readmissions that no one else ever thinks of." ■

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Opioid Use and the Role of the Case Manager

By Jeni Miller

Regardless of whether they know it, many case managers are faced with patients and clients each day who are struggling with opioid use disorder (OUD). As rates of OUD continue to increase, it is essential for case managers to hone their skills of confidently recognizing and addressing the disorder. The prescribing of opioids may have been (and still may be) for good reason, but the consequences have presented severe challenges.

"[Opioid use] stems from prescribing practices dating back to the late 1980s to the early 1990s when the medical profession believed we were inadequately addressing the needs of acute and chronic pain," explains **Rebecca Perez**, MSN, RN, CCM, senior manager of education and strategic partnerships with Parthenon Management Group. "Pharmaceutical companies that manufactured opiate medications assured prescribers that these medications were safe, and addiction was unlikely."

Unfortunately, addiction was anything but unlikely.

Perez describes how "those challenged with OUD are not the stereotypical drug addict. They are injured veterans returned from multiple tours in the Middle East, individuals with medical conditions that result in chronic pain, or pregnant mothers who suffered from chronic pain before getting pregnant. All who believed they were receiving treatment for their respective conditions and now are told that they should not be taking these medications."

The result, says Perez, is the use, misuse, and abuse of opiates. The problem is escalating as deaths from overdose reach "epidemic proportions." The stigma of drug abuse has hindered access to treatment for OUD — all while individuals struggling with it find other ways to control their pain and fill the void.

"Many of those with dependence on opiates who have found themselves now without their prescriptions seek illicit forms of opiates like fentanyl, or other illegal drugs mixed with fentanyl, increasing the overdose rate," said Perez.

What factors should case managers consider as they seek to support their patients struggling with OUD? What should they know regarding the "assessment, care planning process, and intervention development to address opioid use disorder?" For Perez, "assessing the patient's history is vital." Three aspects of the patient's history should be considered.

First, "Knowing what precipitated the use of opiates is very important," Perez explains. "Most often, the patient suffered a traumatic injury or has a condition resulting in chronic pain. The cause of the pain needs to be understood so that alternatives to pain management can be facilitated."

As the case manager develops a care plan for their patient, also should consider a second piece of the patient's history: potential drug or alcohol misuse or abuse. This history, according to Perez, "leaves an individual vulnerable to other addictions."

Finally, a history of mental illness or behavioral disorders can affect the use or misuse of substances.

"If mental or behavioral conditions are poorly managed, individuals may attempt to self-medicate to improve or stabilize mood," Perez notes.

In addition to the patient's history, assessment for social challenges may be "just as crucial," according to Perez.

"Social barriers prevent individuals from accessing needed care," she adds. "Knowing these potential risks helps develop a more targeted care plan with interventions tailored to the individual."

Due to the all-encompassing nature of their role, case managers play an integral part in helping patients access treatment options. Case managers should continue educating themselves about opioid use and its effect on their patients and community. "Case managers are life-long learners," Perez explains. "They need to stay on the cutting edge of how best practices evolve. Providing resources on how and where to guide patients to treatment is one of the most critical interventions."

"Until just a few years ago, medication-assisted treatment [MAT] for OUD was not included as first-line treatment, and treatment was not always easy to find or access," she continues. "Mental health treatment, in general, has not been a priority in our healthcare system. However, with epidemic rates of overdose, OUD has become a priority, and treatment — primarily MAT — has become best practice and more readily accessible."

To help case managers access reliable and timely information, the Case Management Society of America created its *Opioid Use Disorder Guide Case Management Guide* to provide resources for assessment and care planning specifically for this condition. The guide is available at: https://bit.ly/3dPhq03. ■

Leaders Plot How They Will Leverage the Lessons of COVID-19

By Dorothy Brooks

While healthcare leaders continue to battle a global pandemic, many also are plotting how they will use the lessons of this emergency to make their health systems better. Several shared their ideas during the Institute for Healthcare Improvement's annual forum in December.

Already, there is much more focus on the importance of caregiver well-being and how to sustain clinicians through extended emergencies, observed **Amy Compton-Phillips**, MD, executive vice president and chief clinical officer for Providence St. Joseph Health. "We have had mass shootings and we have had wildfires ... so we have had a lot of experience in dealing with calamity, but we haven't had experience in dealing with a calamity that goes on for a year and half," she said. "We are figuring out how we sustain the people who are sustaining the patients and sustaining our communities so that we can continue to be resilient into the future."

Frontline clinicians are exhausted. Still, after passing through two COVID-19 waves (so far), Compton-Phillips sees resilience. "I think that attitude is really what has been sustaining [clinical staff] through this current wave ... they know that because they have done it before, they can do it again," she said.

There also is renewed appreciation for the value of peer support, noted **James Mountford**, BM, BCh, MPH, director of National Improvement Strategy for the National Health Service in the United Kingdom. "When you look at some of the literature from military situations ... having escalating support is important. Probably the thing that makes the biggest difference to the most number of people is a little bit of time to just talk to peers on the principle that a problem shared is a problem halved," he explained.

The speed with which clinicians can innovate and improve has been eye-opening for both leaders and staff, according to Compton-Phillips. "The inpatient mortality rate [for COVID-19 patients] has gone from 25% down to the single digits, which is amazing. That is rapid improvement. It is a testament to the fact that when we focus on [an issue], admit that we don't know something, and put in the tools to measure and improve, it makes a huge difference," she noted. "I do think that now that we have done this, and we have done it in a broad way, we can actually leverage those skills in moving forward."

To fully reap the rewards of innovation, **Michael Dowling**, president and CEO of Northwell Health, stated there needs to be changes regarding regulations and compliance. "Innovation blossoms during a crisis, and it is no different this time," he said. "We have been able to do things during COVID that we dream of doing in non-COVID times."

For instance, when regulations were eased in New York when COVID-19 cases peaked there last spring, easing regulations enabled Northwell to respond quickly. "I remember sitting in meetings where [we] had to, overnight, create a couple hundred beds," Dowling recalled. "[We] just let people go do and figure it out, break the rules."

People pushed the envelope and did not worry too much about who was going to be upset. Dowling stressed this attitude must continue. "I am afraid when this is all over, government especially will go back and put all of the constraints back on again," he lamented.

Too often, government bureaucracy has been disassociated with what is happening on the frontlines, according to Dowling. "We need good people to go into government that have real-life experience on the ground," he said. "We should be encouraging young people to go in and help reform that side of [healthcare] as well."

Considering the acceleration of technology like telemedicine and remote work, leaders will have to reimagine how they deliver care. "It is going to be forced upon us rather than us initiating it because the world has changed as a result of COVID," Dowling said. "It will never go back to the same way." ■

COMING IN FUTURE MONTHS

- Data analytics will drive case management
- Pandemic ethical dilemmas confront nurses case managers
- Integrated behavioral health and chronic illness treatment works
- Case managers can become involved with public policy

HOSPITAL
CASE MANAGEMENT

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CE QUESTIONS

1. **How many hospital days were saved by a hospital partnership with a local skilled nursing facility?**

   a. 483
   b. 899
   c. 2,382
   d. 701

2. **Which is one of the most common characteristics included in the Discharge Referral Expert System for Care Transitions (DIRECT) algorithm?**

   a. Number of falls
   b. Caregiver status
   c. Behavioral health issues
   d. Number of daily medications

3. **What are the two main considerations for occupational therapists when consulting on a patient's transition of care?**

   a. Health and wellness
   b. Cognition and home environment
   c. Caregivers and health
   d. Cost and function

4. **Which should case managers primarily consider when seeking to support patients struggling with opioid use disorder?**

   a. Race
   b. Age
   c. Gender
   d. History

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.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

The Basic Elements of Healthcare Reimbursement, Part 3

By Toni Cesta, PhD, RN, FAAN

Introduction

In this month's issue, the conversation on healthcare reimbursement turns to the additional prospective payment systems found across the continuum of care. Prospective payment remains a way in which the Centers for Medicare & Medicaid Services (CMS) can determine the rates for care based on predetermined amounts rather than on billing. The processes are similar to the use of the diagnosis-related groups (DRGs) in the acute care setting, with some differences. We will continue with a review of the various reimbursement schemes in outpatient settings.

Inpatient Only List

As the cost of acute care continued to escalate in the 1990s, it made sense for CMS to turn its attention to other levels of care that could be provided at lower cost. This includes ambulatory and outpatient settings, such as emergency departments, ambulatory surgery, clinics, and patient-centered medical homes. Because of the rising cost of inpatient care, these other, lower-cost settings became more viable for certain diagnoses and surgical procedures that could be adequately treated in a lower level of care.

CMS also implemented the Inpatient Only (IPO) list. This list includes procedures that CMS will only reimburse in an acute level of care. These surgeries require more care than can be provided safely in an inpatient setting. Currently, surgical procedures are being removed from the IPO list, with the plan of phasing the IPO out completely by 2024.[1] This is a testament to the ability of these outpatient settings to manage more complex patients over time. Hospitals and case management professionals must ensure patients receiving services on the IPO list are admitted to the hospital and not registered as ambulatory sugery patients. When this happens, the hospital is at risk for losing reimbursement for that procedure.

CMS created the Prospective Payment System (PPS) for hospital outpatient services in 1997 as part of the Balanced Budget Act. The final rules were implemented in 2000. CMS had officially started the process of controlling costs in the outpatient settings, not just in acute care.

Ambulatory Payment Classifications

The ambulatory payment classification (APC) system was implemented first. It is defined as an encounter-based patient classification system designed to reimburse for one or more patient encounters. We will review more of this later. Reimbursement based on encounter is a fundamental difference between APCs and DRGs. It identifies like groups of patients in similar fashion to the Inpatient Prospective Payment System (IPPS) and uses predetermined rates. The difference is each outpatient encounter can include multiple APC systems. As with DRGs, the APCs predict the amount and types of resources to be consumed.

The initial APC list consisted of 451 ambulatory payment classification groups. Like DRGs, the groupings and the reimbursement reflect categories similar in resource use and cost. This piece of the APC system mirrors the DRGs.

The APC system uses a process called mapping. Mapping aligns each patient encounter to a particular APC based on CPT codes. Each APC also is assigned a status indicator. The status indicator defines if and how a service will be paid. Not all status indicators are paid under an APC. Therefore, all services provided during an

encounter may not be mapped to a single APC.

APC groupings and number of APC systems in each group:

- Significant procedures: 240;
- Medical visits: 7;
- Ancillary: 39;
- New technology: 15;
- Transitional pass-through: 132;
- Extensive pharmaceuticals: 17;
- Partial hospitalization: 1;
- Total: 451.

Procedure APCs include surgical and nonsurgical procedures. Nonsurgical procedures include nuclear medicine, MRI, radiation therapy, and psychotherapy.

Other items also may be mapped in. One example is pass-through items, which include drugs, biologicals, and devices that can be claimed for reimbursement in addition to the APC payment if certain CMS criteria are met. Examples of these items are pacemaker devices, cataract lenses, and cardiac catheterization lead wires. Many of these are high-cost items and receive a separate reimbursement.

In some cases, all resources applied to a service are bundled together. Examples include:

- Anesthesia;
- Recovery and treatment rooms;
- Operating room;
- Drugs and pharmaceuticals (with exceptions);
- Medical/surgical supplies;
- Observation services;
- Implantable devices;
- Donor tissue;
- Exceptions to packaged services include: Drugs, pharmaceuticals, biologicals, and/or devices that are eligible for transitional pass-through payments;
- Other specific services defined by CMS:
  - Corneal tissue acquisition;
  - Casting, splinting, and strapping;
  - Blood and blood products;
  - Certain other high-cost drugs.

It would be difficult to itemize these encounters due to the large number of resources used.

The total reimbursement of an encounter is the sum of the individual payments for each service. An outpatient visit might include APC- as well as non-APC-related payments. The total determines the final reimbursement.

Comparing APCs and DRGs:

- APCs follow the same methodology as DRGs;
- Similar groupings of patient types are prospectively identified with corresponding reimbursement amounts;
- Unlike DRGs, a single outpatient encounter can result in the payment of one or more APCs.

The Scope of the OPPS

The Outpatient Prospective Payment System (OPPS) applies to acute care hospitals. It includes hospitals exempt from the IPPS, and partial hospitalization services provided by community mental health centers. Cancer centers that are exempted from the IPPS are held permanently harmless for payment reductions. This means the center must use the same infrastructure for mapping and billing under the OPPS, but reimbursement will be supplemented if it is negatively affected.

Included Services:

- Emergency department (ED) visits;
- Clinic visits;
- Surgical procedures;
- Radiology;
- Chemotherapy;
- Most ancillary services;
- Partial hospitalization program services.

Excluded Services:

- Ambulance services;
- Rehabilitation therapy services;
- Laboratory services paid under a fee schedule;
- End-stage renal disease (routine dialysis services) and Epoetin;
- Services provided by critical access hospitals;
- Durable medical equipment;
- Orthotic/prosthetic devices;
- Screening mammography.

Clinics, EDs, and Critical Care Services

Critical care, ED visits, and clinic visits are assigned to one of seven APC groups based on 31 Evaluation and Management (E&M) CPT-4 codes. Hospital-based clinics use three APCs: low, medium, and high. Assignment is similarly based on the CPT-4 code identified. EDs also use the low, medium, and high categories, identified based on the CPT-4 code. Critical care uses one CPT.

Observation Services

Under the new system, observation is no longer reimbursed separately. It is part of the APC payment, either ED or ambulatory surgery. Exceptions are congestive heart failure, asthma, and chest pain. Patients admitted to observation with one of these diagnoses are mapped to their own APC.

Each hospital is required to develop its own mapping system and determine which items will be mapped to either high, medium, or low APC groupings. The hospital is

required to link this information to a computer system and to billing.

Home Care Prospective Payment System

Prospective payment for home care visits was implemented in October 2000. The home care PPS structure is based on a nursing assessment tool completed when the patient is admitted for these services. Reimbursement is based on an episode of care and/or 60 days of care. The dollar amount is fixed regardless of the number of visits.

The home care PPS is the only PPS that relies on a nursing assessment to drive reimbursement. The Outcome and Assessment Information Set (OASIS) data must be accurate as it is related directly to reimbursement. Home health resource groups (HHRGs) are similar to DRGs and APCs.

OASIS

The home care nurse completes the OASIS tool. Scoring is based on three categories:

- Clinical category with four items;
- Functional category with five items;
- Service utilization category with four items.

The final score results in the assignment of one of 80 HHRGs. Like the DRGs, each HHRG includes a predetermined dollar amount.

Reimbursement for a HHRG relates to the level of home care provided. Each HHRG holds a fixed national rate similar to the DRGs. The only item not included is durable medical equipment. The base rate is adjusted or added for exceptional items. All disciplines are included as well as non-routine medical supplies. It also includes the cost of managing the OASIS, as this requires additional resources and time to complete. CMS regularly adjusts these rates.

Final Payment

CMS pays for all line items and services provided at the end of the 60-day period. Example (numbers and dollar amounts are for demonstration purposes only):

- Standard Prospective Payment Rate: $2,037.04;
- Case Mix Payment Rate for C0F050: ×0.5265%;
- Case Mix Adjusted PPS Payment Amount: $1,072.50.

Wage Index Adjustments

- Case Mix Adjusted PPS Payment Amount: $1,072.50;
- Labor Percentage of PPS Payment Rate: ×0.77668%;
- Labor Portion: $832.99.

The labor portion is then multiplied by the Wage Index Factor:

- Labor Portion: $832.99;
- Wage Index Factor: ×1.1 (example);
- Adjusted Labor Portion: $916.29.

Nonlabor Portion

- Case Mix Adjusted Amount: $1,072.50;
- Nonlabor Percentage: ×0.2233%;
- Adjusted Nonlabor Portion: $239.49;
- Labor Portion: $916.29;
- Nonlabor Portion: ×239.49;
- Total Case Mix and Wage Adjusted PPS Rate: $1,155.78.

There are times when the patient does not complete the 60-day home care episode. When one of two situations occurs, CMS will provide some payment.

The first is if a patient elects to leave one home care agency and transfer to another. The second occurs if the patient leaves the home care agency, but returns within 60 days. These payments are called partial episode payments (PEP). The PEP can be applied only if the transfer or discharge and return was not due to a change in the patient's condition.The amount paid is prorated to the actual number of times the patient was seen by home care. For example, if the patient was seen for 30 of the 60 days, the PEP would be calculated as 30/60 multiplied by the full original payment amount. In this case, the home care agency would receive half the original payment.

Significant Change in Condition Payment

If a clinically significant change occurs in the patient's status and a new OASIS is initiated, as well as a new HHRG and new physician orders, a special rate would be applied. The change must be unexpected and cause an interruption in the 60-day episode of care. As with the partial episode payment, the home care agency would receive a prorated amount. This includes a partial payment based on the original HHRG, and an additional payment. This second payment is called the "significant change in condition" payment, or SCIC.

Low-Utilization Payment

A patient can receive home care for shorter periods, called low-utilization. In these cases, a low-utilization payment adjustment is made. The home health agency is paid based on the national standard rate

for each discipline. These amounts are adjusted based on wage area index but not on case mix.

Outlier Payments

When the cost of care for a patient differs greatly from the usual amount of medically necessary home care, CMS will consider an outlier payment. Two elements are considered before such payments are made:

- The cost of services should exceed the payment;
- The outlier payment should be less than the total amount of the cost above the outlier threshold.

The amount of the outlier payment is limited to 5% of the total prospective payment. The fixed-dollar loss amount is now 1.13 times the standard episode amount.

Important Points to Consider

The home care PPS has driven home care to think about appropriate use of resources rather than arbitrarily spending on a patient. When home care shifted to PPS, agencies began considering the coordination of the financial and clinical aspects of a patient's care. Determining the correct number of visits based on clinical need became the driver of care.

It also is critical to timely and accurately complete the OASIS, as it determines the reimbursement to the home care agency. Home care agencies use these data to benchmark best practices and determine profits and losses. This information helps the agency understand where it might need new product lines, or where others might be eliminated. The HHRG data also helps in analyzing where costs may be too high in managing specific types of patients.

Home health agencies use many tools from the acute care setting to manage costs and visits. One such tool is the clinical practice guidelines for specific case types that provides a structure for interventions for each visit as well as expected resource use. Implementation of clinical practice guidelines helps prospectively ensure the correct resources are applied in a timely manner. Because of the variation among patients and for some high-risk groups, one can assume these high-risk groups are more likely to use excess resources if not managed proactively.

High-risk assessment criteria identify these patients. Many home care agencies use RN case managers to manage these high-risk patients. In some instances, the OASIS can provide much of the data necessary to identify patients at greater risk for poor outcomes or greater resource use.

Summary

Each level of care across the continuum uses similar payment schemes that reflect CMS's goals of managing costs and requiring healthcare providers to use case management skills to optimize their reimbursement. ■

REFERENCE

1. Centers for Medicare & Medicaid Services. Fact sheet: CY 2021 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System final rule (CMS-1736-FC). Dec. 2, 2020. https://go.cms.gov/3klyvjq