AMERICAN HEALTH CONSULTANTS®

HOSPITAL CASE MANAGEMENT™

the monthly update on hospital-based care planning and critical paths

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Reduce costs, improve outcomes with community case management

How to set up community CM at your facility

As reimbursement continues to shrink for Medicare patients and home health agencies, there is increasing concern about the fate of elderly and chronically ill patients. Seniors and others with complex comorbidities often are left to find their way through a complicated health care system with minimal guidance. The task can be daunting.

Enter community case management, which increasingly is being considered a solution to the problems facing doctors and hospitals trying to care for this population with less help from the government.

"Community case management is a strategy [that] . . . assesses, plans, coordinates, implements, monitors, and evaluates the services and options needed to meet the health care needs of our patients in a high-quality, customer-focused, and cost-effective manner," explains **Tracy Carver**, RN, MSN, director of client services for the Internet health care site Canopy.com, in a white paper on the subject.

Carver designed and piloted a community case management program while doing her graduate studies and internship at Duke University in Durham, NC.

"My experience was with an outreach program. I kept clinic hours at different sites and saw patients on a scheduled or walk-in basis. I would leave a form behind for patients to fill out if I wasn't there,

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COMING IN FUTURE ISSUES

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- *Critical Path Network* featuring acute myocardial infarction

saying what the problem was and then follow up by phone or with an office visit."

Carver recalls how the program grew in the estimation of the physicians whose patients she helped and the savings this generated both for physicians and the hospital. "My biggest hurdle," she says, "was selling the docs on my role initially. The first couple of referrals were hard to get. But more and more they grew to depend on me. Eventually I started helping to screen their patients by looking at admission patterns, emergency room [ER] visits, and so forth. I could then tell the doctor which patients should be seen by me." She could spend the necessary time with the older, fragile diabetics and arthritic people and work with them to help them understand their medication regimen, their diets, and their other needs. And she says it didn't take long for the physicians to realize how much time she was saving them and how much expense she was deflecting.

And how did Carver justify the expense of her program to Duke Medical Center?

In fact, a hospital-based community case management program needn't be a budget-killer. "There's no new overhead for office space," Carver explains. "It's not necessary to hire extra staff and incur other high-end expenses." In essence, her budget looked something like this:

1. Salary for the case manager: benefits, taxes, etc.

2. Equipment — personal: pager, cell phone, laptop computer.

3. Equipment — office: phone, fax, printer, computer software, filing cabinet.

4. Materials: paper, pens, file folders, computer disks (minimal — most records are computerized).

5. Mileage.

Rebecca Zaseck, executive director of Area 2 Agency on the Aging in South Bend, IN, agrees that a budget for a community case management program need not be elaborate. "Case management hours are determined by the need for intervention and coordination and are billed to the funding source," she says. (This could be either the hospital, Medicare, Medicaid, or another payer.) "If a physical therapist or a nutritionist is needed, that is billed on its own. If home care is needed, that's billed separately."

Zaseck recommends developing a care plan for patients to identify how much case management and how many ancillary services are needed. "Conduct an assessment to determine which services are needed — home health aide, meals, [physical therapy] — to keep the patient

Goals for a community-based case management program

- ✔ Increase utilization of preventative services.
- ✔ Decrease the number of hospitalizations and emergency department (ED) visits to less than two combined hospitalizations and ED visits yearly.
- ✔ Decrease inappropriate utilization of health care services.
- ✔ Identify patients who are at risk for long lengths of stay, high cost of utilization, difficulty in placement, and vulnerable for readmission.
- ✔ Permit shared access of assessment and administrative information among authorized caregivers in the hospital, ED, nursing home, physician's office, home health agency, etc.
- ✔ Evaluate medical treatment plans according to current best practices and evidence-based guidelines with complete access to the Internet's store of research and health care information for reference and patient/family education purposes.
- ✔ Improve Medicare margins by reducing length of stay and direct patient costs per inpatient day.
- ✔ Improve the quality of life for the patients by helping them and their providers plan and monitor the significant transitions from inpatient to outpatient and home health settings.
- ✔ Improving communications to all primary stakeholders caring for case managed patients.

Source: Tracy Carver, Director of Client Services, Canopy.com, Chapel Hill, NC. Web site: www.CanopyCentral.com.

in the community. The amount of case management needed also is identified under the plan of care. If you work for a larger organization, you would include the costs for supervision, billing, and office space when building the budget."

Judy Homa-Lowry, RN, MS, CPHQ, president of Homa-Lowry Healthcare Consulting in Canton, MI, cautions that it is wise first to do an assessment of what's currently available in the community and decide how far to take a case management program. For a hospital-based program, she suggests starting by selecting certain product lines. "Instead of going across the board with your plan, be selective. Start out just with obstetrics, for instance, or just teen pregnancy or psych patients."

She suggests emphasizing the cost benefit. "If you decide to provide some of those services after discharge instead of trying to push them all into a two or three-day hospital stay, you may avoid readmissions or additional doctor visits. After all, when a patient is hospitalized, sick, and medicated, it's very difficult to absorb all the instructions and orders. It's so much more effective to see the patient later, one on one, and go over those instructions slowly and personally. Then [the information] has a chance to sink in, and you stand a much better chance of avoiding the [ER] visits, readmissions, and calls to the doctor."

"Some people just look at start-up or maintenance costs, but not necessarily at the savings to the institution as a whole or the benefit to the patient." She encourages that any proposed budget should emphasize the value of one-on-one education and reduced visits back to the clinic.

Itemize the cost of an hour in the ER, a one-day hospital admission, or a visit to the doctor's office, and compare it to the cost of four hours of a case manager's time. It will illustrate an impressive difference.

Once you've selected a product line and conducted a cost-benefit analysis, Homa-Lowry suggests putting together a simple budget. "But first look and see what resources are currently available through donations, specialty services, or volunteers," she says.

Carver agrees that volunteer services can be a huge benefit to a case management program. "Rather than allocate a medical director," she explains, "we got different doctors from different specialties to volunteer to help on an as-needed basis."

Though some might wonder at the reality of calling in those promises when the time comes, Carver says, "in truth, I probably only called upon each individual about four times a year." And she had so proven the value of her program to the doctors that they were happy to oblige. "I saved the docs a lot of time by serving as a patient advocate. It formed enormous goodwill between me and physicians, and they were happy to volunteer when I asked them to. The community case management program represented a big cost savings to doctors who might otherwise have needed to spend a half hour dealing with a Medicare patient."

In her white paper on the subject, Carver concludes that "the cost benefit of this community-wide case management program will show how specific case management interventions directly improve patient outcomes while reducing cost, decreasing inappropriate utilization, reducing

admissions/readmissions, decreasing length of inpatient stay, improving quality of life, and increasing patient satisfaction."

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Ready? What to expect from rehabilitation PPS

New rules are effective April 1

As the fallout from the Balanced Budget Act of 1997 (BBA) continues to sift down, the nation's 1,100 inpatient rehabilitation facilities will be the next to struggle with the Health Care Finance Administration's (HCFA) prospective payment system (PPS). This means hospital case managers nationwide will be looking at new limitations and cost structures as they work with patients already in or destined for rehab facilities and units.

Rehabilitation facilities, which provide extensive occupational, physical, and speech therapy services, have been exempt from the PPS until now. But the BBA requires HCFA to implement a PPS specifically for these facilities.

"These special hospitals provide essential therapy and other care that helps Medicare beneficiaries' recovery from serious disabling illnesses," **Michael Hash**, HCFA acting administrator, said in a prepared statement. "This new system continues our progress in ensuring Medicare appropriately pays hospitals and other providers that care for our 39 million Medicare beneficiaries."

The new regulations are effective April 1. According to HCFA, they are "designed to promote quality and efficient care at rehabilitation facilities including both freestanding hospitals and special units in acute-care hospitals."

The new rule, which will be phased in over a two-year period, includes these provisions:

- Rehab facilities will be paid on a per-discharge basis for operational and capital costs.
- There will be comorbidity adjustments for varying degrees of patient needs.
- A transfer provision will determine payments for patients who are transferred to other facilities before their treatment is completed.
- Payments will be adjusted for geographic differences in wages and for disproportionate shares of low-income patients. Rural facilities will receive special adjustments.
- Additional adjustments will be made for outlier cases.
- Facilities will use the Minimum Dataset Post-Acute Coding (MDSPAC) assessment tool to determine each patient's needs and appropriate payment categories.

As the clock ticks down, case managers and other rehab professionals are nervous. "It's feeling pretty overwhelming right now," says **Jean O'Leary**, BSN, CCM, CRRN, MPAH, director of case management at Healthsouth New England Rehabilitation Hospital in Woburn, MA. "Some days we wonder if we will survive with the way things are being set up. Currently, we're getting the most complex, most costly person as our patient. And we have to wonder, will we still be able to care for them?"

The rule would include a 2% cut in the payment baseline, a reduction the Chicago-based American Hospital Association (AHA) has been lobbying aggressively to restore. The AHA also makes the point that Medicare has generated more savings from the Balanced Budget Act cuts ($70 billion) than were originally targeted by Congress ($44 billion).

Furthermore, the AHA noted that the Medical Payment Advisory Commission (MedPAC) revealed last June a 4% to 7% reduction in Medicare operating margins for PPS-exempt hospitals and units as a result of the BBA, and recommended a 3% increase in FY 2001 to help these facilities cover inflation costs.

Understandably, rehab hospitals and units as well as case managers are anxious about just how much adjustment they'll be dealing with under the new regulations with the new assessment tool and the payment calculations. According to HCFA, the PPS will use the patient assessment tool "to classify individuals into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group, including the application of case- and facility-level adjustments."

Rehabilitation PPS Highlights

- ❒ Rehabilitation facilities would be paid on a per-discharge basis just as acute-care hospitals are paid. Medicare prospective payments will cover all the costs of furnishing covered inpatient rehabilitation services, including routine, ancillary, and capital costs.
- ❒ Medicare would pay facilities at relatively higher rates to care for patients with more intensive needs. Payment rates would reflect each patient's rehabilitation conditions, functional status (both motor and cognitive, age, related illnesses, and other factors that help to explain the intensity of care.
- ❒ Facilities would use a comprehensive assessment tool to determine the appropriate payment category. These assessments also would allow HCFA and the facilities to monitor and improve the quality of care.
- ❒ The proposal would adjust payments to rehabilitation facilities when a patient is transferred to another hospital or nursing home before completing the full course of care in order to ensure beneficiaries receive adequate care.
- ❒ Payment rates for individual facilities would be adjusted to reflect geographic differences in wages and for providing care to a disproportionate number of low-income patients. Rural providers also would receive a payment adjustment to account for their higher costs.
- ❒ Medicare would make additional payments for outlier cases involving beneficiaries with extraordinary care needs to ensure appropriate care for the sickest beneficiaries.

As the law requires, the new system would establish payment rates so that estimated payments under the PPS are 2% less than the estimated payments that would have been paid under the existing cost-based system. This provision will result in estimated savings for Medicare beneficiaries and taxpayers of $1.5 billion over seven years.

Source: Health Care Financing Administration, Baltimore.

Those payments will be adjusted to account for geographic variations in wages. There also will be additional outlier payments for high-cost cases. HCFA concluded that rural rehabilitation facilities and those serving a large low-income population had higher costs than other facilities and were entitled to an adjustment.

Under the new rule, rehabilitation facilities would be paid based on the characteristics of each individual patient they admit, calculated on a comprehensive assessment of the patient's condition. The PPS replaces the existing cost-based payment system.

But the hitch lies in the payment structure. The rehabilitation PPS would involve each patient discharge being assigned to a functional-related group, which covers a broad range of diagnoses.

"It looks like we'll be paid on functionally related groups despite matters of age, condition, or comorbidity," says O'Leary.

The American Medical Rehabilitation Providers Association (AMRPA) worries that Medicare patients will comes out losers "because a poorly designed payment system that cannot be easily reformed will lead to limitation on access and appropriate care."

And then there is MDSPAC, the coding tool that is not being cheerfully received.

"What's giving us nightmares right now," says **Joyce Speakman**, CFO at Spalding Rehabilitation Center in Denver, "is the fact that we're going to have to complete an MDSPAC. Currently, we have a tool that does what we need for selecting codes. It's a very easy instrument to use and takes about five minutes to do. The MDSPAC could take hours. It's also completely opposite from the way we've previously managed coding, and it will mean reconverting certain codes."

It's not yet popular with case managers either. "The coding actually starts with the person who screens the admission," explains O'Leary. "They assess where the patient may fall code-wise. The case manager will verify if this is right. Screeners may find it a useful tool to work with, but case managers are still not sure about certain specific costs."

The MDSPAC was adopted at the urging of MedPAC and HCFA's contractor, RAND Corporation, to ensure consistent assessments across all Medicare settings.

It was felt that the functional independence measures, which initially were considered, did not satisfactorily reflect speech-language pathology (SLP) services. While SLP services are more adequately recognized in the MDSPAC, the American Speech and Hearing Association will continue to seek modifications to the MDSPAC system to ensure that access to high-quality SLP treatment is not adversely affected by the new PPS.

O'Leary says Healthsouth is looking at new strategies to meet the challenge before the April 1 deadline. "Our case management department is

being empowered to direct patient care around patient needs rather than length of stay and cost," she explains.

"Meantime, we're looking individually at our amputee population, our spinal cord population, our cardiac, stroke, and other patients to assess diagnostic needs. We're looking at our 1999-2000 history to see how many more admissions we'll need in order to break even under the new regulations, and we're developing ways to maximize our commercial reimbursements," O'Leary says.

The AHA says that its top legislative priority for rehabilitation will be to restore the scheduled 2% reduction in rehabilitation PPS. The Lewin Group, AHA's consulting firm in Washington, DC, has analyzed the scheduled cut and documented significant declines in Medicare margins for rehabilitation hospitals and units. This was similar to MedPAC's conclusions, which led to its recommendation to increase funding for PPS-exempt facilities in 2001.

Edward A. Eckenhof, AMRPA chairman, made that point and more in his statement to the House Ways and Means Committee's Subcommittee on Health last summer.

He pointed out that "overall Medicare outlays for services delivered by rehabilitation hospitals or units have been reduced by more than $600 million over three years. And although rehabilitation spending comprises just 2.3% of total Medicare spending, rehabilitation hospitals and units have been forced to absorb almost 4.3% of BBA 97 spending reductions."

He also noted that from 1997 to 1998, Medicare margins for rehabilitation facilities decreased from 6.3% to 1.8%.

Eckenhof explained that for rehabilitation hospitals and units, Medicare accounts for approximately 70% of all discharges and revenues. "Therefore, even temporary changes in Medicare reimbursement can threaten the security of a great number of facilities and, consequently, the patients we serve."

It's a scary prospect, says Speakman. "Until it actually starts to happen, we won't really know the impact."

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Home health PPS makes discharge planning harder

The Health Care Financing Administration's (HCFA) new prospective payment system (PPS) for home health represents a challenge to hospital case managers as well as the home health industry itself. With funding reduced and documentation increased, many home health agencies find themselves scrambling to serve patients and break even financially. Meanwhile, hospital-based case managers have had to worry about whether agencies will be able to accept the patients that hospitals send their way. It's been a tough adjustment with a long learning curve, and things are still in flux.

When PPS became effective in October 2000, home health professionals found there was plenty of culture shock to deal with. There were time-consuming but critically important OASIS (Outcome and Assessment Standardized Information Set) assessments to be completed with each admission. There were the home health resource groups (HHRGs), which categorize each case and determine utilization and cost. There were new coding issues and utilization factors.

"And it's affected case managers in all areas," says **Sandra Lowry**, RN, BSN, BRRN, CCM, president of the Case Management Society of America in Little Rock, AR. "Home care has suddenly realized the impact of PPS, and the anxiety level is becoming quite high. Agencies are now scrambling to develop strategies to deal with the new system. And I see some real opportunity there to make this work and to bring down costs."

Fazzi Associates Inc., a Northampton, MA-based planning, training, and management consulting firm, was selected by the National Association for Home Health Care in Washington, DC, to help develop strategies to deal with PPS before it became law.

In its report to the industry titled "Ground Point Zero," Fazzi emphasized the importance of developing strategies that serve the agency and the patient rather than those built around individual departments and turf protection. The report stressed the need for utilization guidelines for each HHRG. Agencies were urged to educate their staff on the OASIS assessments and the necessity of consistency and follow-through "since it will

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CRITICAL PATH NETWORK™

Improving client education with the patient pathway

Marilyn Hanchett, RN, MA, CPHQ
Coordinator, Clinical Pathways
Jean O'Neal, RN
Manager, Registration Services
Columbia (MO) Regional Hospital

Clinical pathways were introduced in 1995 at Columbia Regional Hospital, a 100-bed community hospital, which is now affiliated with University of Missouri Health Care, also in Columbia. At that time, project manager **Jean O'Neal**, RN, developed an innovative tool for educating and involving patients in their care.

The patient pathway corresponds to the clinical pathway but is a separate document. It is a day-to-day compilation of what the patient can expect to happen and describes the patient's responsibilities for those activities. The patient pathway uses simple terminology and is based on a seventh-grade Flesch-Kincaid reading level. Unlike the clinical pathway, which is part of the medical record, the patient pathway is given to the client. He or she is encouraged to refer to it regularly and use it as a resource throughout the hospital stay.

Depending on the reason for admission, the patient may be introduced to the pathway at a variety of entry points. For example, a female client who is discussing a hysterectomy with the surgeon may receive the patient pathway in the doctor's office prior to the actual surgery date. A patient who arrives for preoperative evaluation prior to joint replacement surgery will receive the pathway in the outpatient department. "In both examples," O'Neal points out, "the patient has an opportunity to ask questions before being admitted."

Since their introduction in 1995, patient pathways have become an integral part of the hospital's Preoperative Education and Testing (POET) Program. **Sheila Corey**, RN, who coordinates the POET Program in conjunction with the hospital's Institute for Outpatient Surgery, has seen the immediate impact of the tool during her daily teaching sessions. "Many times patients are more than just anxious; they are afraid. By going over the patient pathway with them and their family members, they know what to expect. They have a better understanding of what will happen and if they forget, they can refer back to the pathway." In fact, Corey says that the pathways have been a critical component in maintaining the consistently high customer satisfaction scores achieved by the POET Program.

It is important to remember that the patient pathway does not preclude the use of other types of patient education materials. However, unlike disease, procedure, or treatment-specific teaching aids, the patient pathway helps explain the hospital experience. The case manager is the champion for the clinical pathway. In this role, he or she also is responsible for ensuring the patient pathways are current, relevant, and available to the various users throughout the hospital system. Case managers work closely with physicians and their assistants to assure the accuracy of all pathway materials. In many cases, the case manager supplies physician offices with copies of all pathway information.

Case managers, as well as all other members of the health care team, struggle to balance the need for thorough patient education with the demand for cost-effective resource utilization. Preadmission education, especially for surgical cases, has been identified as an effective measure in reducing

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PATIENT PATHWAY for Abdominal/Vaginal Hysterectomy

Patient Name	
Admission Date	
Surgeon	
Medical Doctor	

GOAL

The purpose of this hysterectomy "PATHWAY" is to provide you with the information about your treatment plan so you can actively participate in the recovery process. Our goal is to assist you in acquiring all of the necessary skills and information needed to return you to your normal activity level as soon as possible.

CATEGORY	PRIOR TO SURGERY
YOUR JOB IS TO:	1. Make sure your admission to the hospital is pre-certified if your insurance company required it. 2. Supply a list of your medicines you are currently taking. 3. Answer questions about your past medical history. 4. Follow pre-surgery instructions that will be presented to you by the nurse or Dr. 5. Review your pathway and education sheets with nursing staff. 6. Ask questions or talk about your concerns any time during your stay.
TESTS/PROCEDURES:	You will have some blood drawn before surgery. You may also get a chest X-ray and an EKG. You will also be taught some deep breathing and coughing exercises. A nurse will teach you how to use a special pain medicine pump, which you will use after your surgery.
MEDICATION:	Take your regular medicines as instructed by your doctor.
NUTRITION:	On the evening before your surgery you may have only clear liquids to eat or drink. You are not to eat or drink anything after midnight before your surgery.
PATIENT SIGNATURE	
NURSE SIGNATURE	

Columbia Regional Hospital
Patient Pathway for Abdominal & Vaginal Hysterectomy
11-00 CRH
Developed by: 5 North Surgical Staff
M. Hausman RN, CCM

Place Addressograph Here

CATEGORY	AFTER SURGERY	FIRST DAY AFTER SURGERY
YOUR JOB IS TO:	1. Deep breathe (using incentive spirometer) turn, cough, & deep breathe as instructed. 2. Use your pain medicine (PCA) when you need it. This will also help you to deep breathe & cough more effectively. 3. Review your pathway with nursing staff. 4. Follow instructions & help as much as possible with your daily activities. 5. Ask questions or talk about your concerns at any time.	1. Continue to do your deep breathing exercises (including incentive spirometer) every two hours. 2. Review your pathway with nursing staff. 3. Ask questions or talk about any concerns of going home tomorrow. 4. Ask for pain medications when you need it. 5. Follow instructions & help as much as possible with your daily activities.
TEST/PROCEDURES	You may have a tube in your bladder to drain urine. You may also have your feet in a gently pulsating "sock" which will improve leg circulation and help to prevent a blood clot.	You will have some blood drawn.
NURSING STAFF	Your nurse will encourage you to cough & deep breath frequently. The nurse will check your incision, vaginal discharge, vital signs (temperature, pulse, and blood pressure). You will be assisted to sit on the side of the bed and may walk a few steps the evening of surgery. The nursing staff will be caring for you & monitoring your condition. They will be explaining procedures to you. Your job is to inform them of any & all difficulties, discomforts, or symptoms you may feel.	The following will probably be removed: 1. vaginal packing if present 2. the tube in your bladder 3. the dressing on your incision if TAH. You will be encouraged to get up in the chair or walk in the hall at least three or four times a day (this improves bowel functioning). The nursing staff will be caring for you and monitoring your condition. They will be explaining procedures to you. Your job is to inform the nursing staff of any & all difficulties, discomforts, or symptoms you may feel. This is the time to ask questions about going home. Let your nurse know if you do not have assistance at home. Your nurse will discuss activities, driving, lifting, caring for incision, medications.
MEDICATION	You will have pain medicine available in the PCA. Be sure to use it to control your pain. Ask for nausea medicine if you feel nauseated or have an upset stomach. You will continue to have IV fluids & other medicines (such as antibiotics) given to you. You may by started on estrogen replacement medication. Your home medications will be started according to your doctor's orders.	Your IV will be discontinued if you are tolerating your diet, passing flatus, afebrile, and not receiving IV medications. Your PCA (pain pump) will be discontinued. Medications are available for gas, discomfort, & upset stomach. Ask your nurse & doctor about estrogen replacement therapy if you have questions.
NUTRITION	You may be given ice chips to moisten your mouth.	Your diet will be increased to include solid food as tolerated.
PASTORAL CONSULT	Chaplain available upon request.	Chaplain available upon request.

CATEGORY	SECOND DAY AFTER SURGERY
YOUR JOB IS TO:	1. Continue to do your deep breathing exercises (including incentive spirometer). 2. Use your pain medicine when you need it. 3. Review your pathway with nursing staff. 4. Follow instructions & help as much as possible with your daily activities. 5. Ask questions or talk about your concerns at any time. 6. Continue to increase your activity level. 7. Review discharge instructions with your health care team. 8. Arrange for a ride home.
TESTS/PROCEDURES	
NURSING STAFF	1. The nurses will continue caring for you as before. As always, keep them informed of how you are feeling & let them know any questions you are having. 2. You may be assisted to the bathroom & may be able to shower. 3. The nurse will encourage you to do as much as possible for yourself in preparation for going home. 4. The nurse will go over appointments for follow up care. 5. Discharge instructions will be given. You'll receive phone numbers to call for help, advice, or questions.
MEDICATION	Medications are available for incision pain, gas discomfort & upset stomach.
NUTRITION	Drink plenty of fluids. Regular diet as tolerated.
PASTORAL CONSULT	Chaplain available upon request.

Source: Columbia (MO) Regional Hospital.

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anxiety, improving postoperative pain management, and enhancing patient satisfaction.[1,2] When given the choice, patients prefer to receive instruction prior to admission / day of surgery.[3,4] However, the impact of preadmission teaching on other patient outcomes has not been fully investigated, nor has it been consistently correlated with reliable indices of recovery.

It is clear that more study is needed. Case managers can be important facilitators in this process. Through the design, use, and evaluation of tools such as the patient pathway, case managers have an opportunity to demonstrate the value of client education / involvement, including the impact on resource utilization and length of hospital stay. This next level of analysis is currently in progress at Columbia Regional Hospital.

Marty Hausman, RN, CCM, who facilitated the revision of Columbia Regional's Abdominal / Vaginal Hysterectomy Pathway, states, "By combining the traditional clinical pathway with tools such as the patient pathway, our case management staff are better able to not only manage tangible resources, but also intangibles such as goals and expectations." **(See sample pathway, pp. 40, 41, and above.)**

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AMBULATORY CARE
QUARTERLY

Regs up EMTALA ante: Help 'remote site' staff comply

If a security guard has a stroke in your hospital parking lot, would your emergency department (ED) staff know how to respond? If a woman goes into labor at a hospital clinic across the street from your ED, do you have a policy to address that scenario?

If your answer is "no," you're not in compliance with new requirements for the Emergency Medical Treatment and Active Labor Act (EMTALA), warns **Charlotte Yeh**, MD, FACEP, medical director for Medicare policy at the National Heritage Insurance Co. in Hingham, MA. As of this month, EMTALA regulations have changed dramatically, she says.

The outpatient prospective payment system regulations issued by the Health Care Financing Administration (HCFA) have expanded EMTALA to include hospital outpatient facilities, which now are required to give anyone with a potential emergency condition a medical screening exam. Staff at these remote sites also must stabilize and, if necessary, transfer the patient. The new regulations became effective Jan. 10, 2001.

"It's now very clear that EMTALA is not just an ED law," Yeh emphasizes.

The new requirements significantly "up the EMTALA ante," says **Larry B. Mellick**, MS, MD, FAAP, FACEP, chair and professor for the department of emergency medicine at the Medical College of Georgia in Augusta. "This new regulation should finally push hospitals to get seriously organized to comply with EMTALA," he states. "The complexity of management and the opportunity for failure have now increased significantly."

Most ED managers are not in compliance with the new rules for remote sites, says **Stephen A. Frew**, JD, president of the Rockford, IL-based Frew Consulting Group, which specializes in EMTALA compliance. "Most do not realize their EMTALA exposures with this new set of regulations."

Here are ways to comply with the new EMTALA regulations:

• **Make sure all ED staff understand that EMTALA cases at remote sites are their responsibility.** Your ED probably will be responsible for direct field control of the people involved at the remote sites, according to Frew. "The ED should be making the transfer contacts if the patient has to go to another facility closer than the home facility," he says.

Staff need to realize that the patient being treated at the remote site is a crisis for the ED, says Frew. "The ED is responsible to enable the lesser trained personnel in the remote site to give good patient care, comply with the safety plan, and comply with EMTALA."

It's essential that all ED staff accept this responsibility, even though the patient didn't come to the ED for care, says Frew. "The biggest thing I fear is that ED staff will consider these calls to be someone else's problem and not handle them appropriately."

You must remind remote site staff that 911 may not be used as a sole source of response, Yeh stresses. "If someone comes in to the lab or surgicenter complaining of chest pain, staff may not simply call 911 and consider their obligation complete," she says. "You may call 911 for support, but you must begin initial stabilization procedures until ambulance personnel arrive."

• **Consider how other hospitals are handling the new requirements.** It's not enough for you to make sure that your hospital is complying with the new regulations, warns **Todd Taylor**, MD, FACEP, an attending ED physician at Good Samaritan Regional Medical Center in Phoenix. "If another hospital has a facility which falls under these regulations near your hospital, you will need to decide how you will deal with requested transfers from such facilities," he says. "You will also need to deal with requests to sign transfer agreements as required by the regulations."

Previously, urgent care centers basically were exempt from EMTALA, says Taylor. "In some

cases, that will now change," he notes. "So hospitals will need to know when they have a duty to report suspected EMTALA violations for 'dumping' from these urgent care centers," he says.

If a patient is deteriorating rapidly, movement from the remote site back to the main campus is not appropriate, and if it is in the patient's best interest to be transferred, you must have prearranged transfer agreements with closer hospitals, says Yeh. The off-site location must provide appropriate transportation, equipment, and personnel to transfer the patient to the second, closer hospital, Yeh adds.

• **Address billing, signage, and record-keeping practices of remote sites.** EMTALA regulations state that you may not delay treatment for preauthorization requests or to collect copayments, Yeh says. "This is especially important for outpatient departments, surgicenters, and lab areas where typically you request copays prior to seeing the patient. If it's an EMTALA-related service, the remote sites should not be doing copays prior to service." Anyone who does intake registration and screening or who might receive questions about payment or copays needs to understand the implications of EMTALA, Yeh advises. "They need to ensure that no one is turned away because of the ability to pay."

Under EMTALA, you need to keep records for five years and post nondiscrimination notices in the ED and admitting area, says Yeh. "Now, this applies to all sites. So outpatient sites must have the same record keeping and nondiscrimination notices and the same on-call availability, as well."

Increased signage for staff at the off-campus departments is needed to remind them of their obligations, recommends Mellick. "Additionally, mandatory educational schedules, job aids, and checklists are needed in an area that will be highly vulnerable to oversight," he stresses.

• **Establish individualized protocols for dealing with emergencies at all off-site locations.** Your plan has to be commensurate with the location's ability to provide treatment, explains **Grena Porto**, ARM, CPHRM, director of clinical risk management for VHA, a Berwyn, PA-based alliance of more than 2,000 community-owned health care organizations. "If the location has physicians and nurses, you'll be required to provide a higher level of screening than a facility that does not have that resource available," she says.

It's not expected that every single freestanding location will be able to provide the same level of care. You must have emergency response protocols individualized to each site's capabilities, says Yeh. "For example, if the site has a physician and nurse, then they are required to do stabilization. If there is no physician or nurse, then personnel must be trained to place a call to the ED describing the patient's condition and begin to initiate transfer requirements if necessary," she says.

• **Make sure that patient consent for transfer is obtained.** Remote site staff will need to obtain consent from patients with an emergency medical condition for transfer to another facility, says Porto. "This is not a time when you can rely on implied consent. This is a challenge for outpatient settings where you often do not have written informed-consent forms."

When transferring a patient, written documentation is critical, Porto underscores. "If it's an outpatient setting and they do not have a physician there, then you need a policy stating who will initiate the transfer documentation." ■

(Continued from page 38)

determine the reimbursement amount that the agency will receive for a patient."

But getting ready for all that wasn't easy.

"The agencies were hit with a double whammy," says Lowry, "because they had to increase staff productivity at a time when the staff were expected to fill out lengthy OASIS forms. It takes an experienced health care staff person 20 minutes to complete a form, and they have to do them for every admission and every readmission. It's Medicare's way of facilitating the reporting of outcomes, then add to that the PPS requirements for looking at the cost per case. It's very demanding time-wise."

Linda Samia, RN, MSN, CNAA, is the chief clinical officer for the Visiting Nurse Service in Saco, ME, and she agrees that staff time is an issue. "It requires more staffing for different functions," she says. "The administrative burden of getting started was a nightmare, and that continues. There was a lot of cost involved in educating staff. We reduced productivity so we could supply visits. For September [the month before the PPS became effective], we had to double up on plans of care. We had to add staff and have them work overtime.

As with most bureaucratic regulations, documentation is crucial. The OASIS assessment is filled out for each admission, and the patient's care must be carefully monitored and documented thereafter to be sure it is consistent with that assessment. Coding also is very important and has a major impact on the level of reimbursement. Once again, the documentation that follows the patient's path of care must support the codes assigned.

Agencies also were warned to be alert for utilization patterns, assuring the government with still more documentation that patient care is not being compromised in the interest of cost. In addition, they were advised that HCFA would be on the lookout for "cherry picking," or choosing patients who could produce the most desirable reimbursement.

"A major issue was the resources that could offer us support," says Samia. "First we had to understand the rules and make sure every claim was properly filed. And, of course, there's an exception to everything. All of that detail created a lot of confusion we didn't anticipate." But she did give HCFA points for coming to the rescue. "They were good about providing clarification

Key Essentials for PPS Preparation

Some of the key findings that Northhampton, MA-based Fazzi Associates' "Ground Point Zero Report" determined were essential to PPS preparation:

- The development of agency-focused strategies and performance measures, rather than those that focus on departments and turf-related considerations.
- Identifying and managing outcome measures and performance indicators.
- Developing and implementing a marketing plan to create a desired case mix. In this case Fazzi found it critical to point out that it is not important to avoid certain, more costly patients. What is important is to recognize that an agency can provide services in a more cost-effective manner to certain patients and should target those patients in its marketing plan. Determine the agency strengths and focus on those cases, rather than on which types of cases to avoid.
- Review and refine admission criteria and identify who has authority to admit patients.
- Educate staff to accurately complete the Outcome and Assessment Standardized Information Set (OASIS) assessment. It is critical that care managers in the field know how to do this, as the OASIS assessment will determine the reimbursement amount that the agency will receive for a patient. Mistakes can be costly.
- Develop utilization guidelines for each home health resource group (HHRG) based on the agency's cost per visit. By establishing guidelines that provide care managers with a clear understanding and targets for visits, the agency will build into its operational structure the ability to monitor clinical performance and cost.
- Create a clinical review function that determines the accuracy of the OASIS assessments. The report recommended that an individual be responsible for reviewing all OASIS assessments, care plan, and admission visit clinical notes to determine whether they are consistent with one another.
- Update and streamline care pathways to incorporate recognition of the utilization guidelines for each HHRG.
- Incorporate alternative services and alternative products as part of the plan of care. It's important to note that under the PPS, reimbursement is not visit-driven. Instead, agencies must work within the limits of the HHRG reimbursement and ask themselves what other resources might benefit the patient.

and communication." Still, there were frustrations on many fronts. "Some agencies couldn't submit their requests for payment because their software systems weren't in sync with HCFA's," Samia recalls. "Then HCFA changed the rules at the 11th hour, throwing us another curve. But HCFA pretty much suspended medical review for the first 45 days and that gave us a reprieve."

The industry's struggles have had trickle-down effects, as well. "From the case managers' perspective," says Lowry, "they are more concerned about whether [the agency] will take the patient than if they can budget for the care. For example, will someone with a brain injury who needs long-term care even be accepted? Home care agencies in some of these cases are reporting that they don't have the staff to handle it. It's a level of concern that hospital case managers didn't used to have."

"There are problems with providing care," Samia adds. "We [the Visiting Nurse Service] are in a good position, but there are certain populations industrywide not being reimbursed based on the amount of care that's necessary, especially the wound population. Some of it depends on the case-mix factors. The majority of home care agencies are losing money on patients who have complex wounds." She says that although Visiting Nurse Service hasn't had to alter its practice, "some have had to limit accepting patients who require twice-a-day visits because it's very costly. Some patients can be very complex with many comorbidities, and there are complicating factors for coding.

"Another thing that has impacted our patients is the consolidated billing of supplies and outpatient services," she says. "We hoped to get relief through legislation, but that's not happening. It's affecting patient care and overall cost and administration. "That's because when patients choose a home health agency, they have to purchase their supplies through that agency. This might be a patient with a long-standing colostomy who is used to buying ostomy supplies at one particular place. But now there's been a different injury, and this person requires wound care. With home health in the picture, he has to change the place where he buys his ostomy supplies as well. This makes patients anxious and makes it important for home health agencies to work with suppliers."

Then there's the shortage of nurses and health care aides. "We'll see a definite shortage in home care nurses," Lowry predicts. The existing nurse shortage is a nationwide problem, and we already face a tremendous shortage of home health aides and homemakers. It's entry-level work for entry-level pay, and people can earn the same money at McDonald's without having to consider the toileting or the heavy lifting. Add to this that the individuals who do this are mostly women, and now mostly women who are older. These jobs require strong backs and younger bodies."

As with any huge bureaucratic reconstruction, things seem chaotic right now.

"We are currently revising our case management model because there are select populations who are at risk," Samia says.

"A lot of the crisis is anxiety," says Lowry. "But some see this is a step to the future, as learning how to manage costs and ultimately come out with a positive result."

Samia's Visiting Nurse Service may be one of those. "We're looking at where we can improve our practice with the PPS. For us, PPS may be a better solution, but that's not the case with every agency."

"It's possible," Lowry concedes "that we'll end up with consolidations of home health agencies. Small ones could go out of business. Larger ones could end up merging. But home health agencies can't just go away. They're too necessary, too well-regarded. We have to have them. I'm convinced it will all settle down eventually."

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Conference targets cost, quality for case managers

Experts will share their proven ideas for successful case management at The 6th Annual Hospital Case Management Conference: Blueprint for Case Management Success: Information, Accountability, and Collaboration, to be held March 25-27, 2001 in Orlando, FL. The conference

is sponsored by American Health Consultants, publisher of *Hospital Case Management*.

The topics offer something for every hospital-based case manager or quality professional. A variety of speakers will address issues including:

- New avenues for community case managers
- Knowledge-driven care coordination
- Creating a heart service line report card
- What you can teach your CEO about managed care
- Values, ethics, and legal parameters in case management
- The ABCs of the Balanced Budget Act
- Reimbursement: An ever-changing process
- Key concepts in case management
- An interdisciplinary practice model for acute-care case management
- Better case management through denial management
- Measuring the impact of case management interventions

Each session sets aside time to ask the experts your most burning questions. Nineteen contact hours of continuing education will be offered.

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Dedicated unit improves care of seniors

A special care unit dedicated to care of older patients improves both outcomes and satisfaction ratings, according to researchers at Summa Health System in Akron, OH.

The study conducted at Summa tested a multicomponent intervention, called Acute Care for Elders (ACE). The trial included 1,531 patients aged 70 or older currently living at home who were admitted to the hospital for an acute medical illness between November 1994 and May 1997. The ACE unit included a specially designed environment with carpeting and a home-like atmosphere. The unit team consists of the patient's nurse, a geriatric clinical nurse specialist, geriatrician, social worker, dietitian, physical therapist, occupational therapist, pharmacist, and home care nurse. Features of the multicomponent ACE intervention include:

- nursing care plans for prevention of disability and rehabilitation;
- early planning for patient discharge;
- review of medical care to prevent complications such as adverse drug reactions.

Patients were randomly assigned to admission to either the ACE unit or a standard room. Findings include:

- Self-reported measures of function did not differ at discharge between the intervention (ACE) group and the usual care group.

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Editorial Questions

For questions or comments, call **Lee Reinauer** at (404) 262-5460.

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• The composite outcome of activities of daily living decline from baseline to nursing home placement was less frequent at 34% in the ACE group compared to 40% in the usual care group.

• There were no significant differences in costs, hospital length of stay, home health visits, or readmissions in the two groups.

• Physical therapy consults were obtained for 42% of the ACE group compared to 36% of the usual care group.

• Restraints were applied to 2% of the ACE patients compared to 6% of the usual care patients.

• Satisfaction with care was higher for the ACE group than for the usual care group. This higher satisfaction rate was recorded in patients, caregivers and their providers, as well as for nurses working with the patients.

"It appears that the ACE model helps older patients remain independent and avoid nursing home placement during the year following hospitalization," says lead author **Steven R. Counsell**, MD, of Summa Health. "These improvements were accomplished without increasing hospital length of stay or costs."

[See: Counsell SR, Holder CM, Liebenauer LL, et al. Effects of a multicomponent intervention on functional outcomes and process of care in hospitalized older patients: A randomized controlled trial of acute care for elders (ACE) in a community hospital. *J Am Ger Soc* 2000; 48:1,572-1,581.] ▼

Gallup: Americans shun Internet for medical data

Most Americans are still wary about storing or transmitting their personal medical information on the Internet, a recent Gallup survey found.

Commissioned by Turlock, CA-based MedicAlert Foundation, an emergency medical information service, the study was the first to survey the general public, not just Internet users. Gallup found that 77% of all respondents rated privacy of their personal health information as "very important," and that 84% said they are "very or somewhat concerned" that personal health information might be made available to others without their consent.

Because of these privacy concerns, only 7% of the respondents told Gallup researchers they were willing to store or transmit personal health information on the Internet, and only 8% would trust the security of a Web site for their information.

By contrast, 90% said they trust their doctors to keep the information private and secure; 66% trust a hospital to do so; 42% trust insurance companies; and 35% trust a managed care company. For more information, go to www.medicalert.org. ■

CE objectives

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

• identify particular clinical, administrative, or regulatory issues related to the profession of case management;

• describe how those issues affect patients, case managers, hospitals, or the health care industry in general;

• cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■