HOSPITAL CASE MANAGEMENT™

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

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IN THIS ISSUE

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Hospital medical records to come under more federal scrutiny than ever

RACs, MACs, CERTs, ZPICs all will perform audits

Some time in the next 18 months or so, four different sets of auditors could be scrutinizing the medical records at your hospital. It's all part of the Centers for Medicare & Medicaid Services' (CMS) Medicare Integrity Program initiative, mandated by the Deficit Reduction Act of 2005, which seeks to eliminate fraud, waste, and abuse in Medicare claims.

In its strategic plan, CMS calls the initiative "the first national strategy to combat fraud and abuse in the 41-year history of the program."

In addition to the Recovery Audit Contractors (RACs) program, which is being rolled out nationwide following a three-year pilot project, hospital records also will be subject to audits from the following:

- Medicare Administrative Contractors (MACs), which will take over and expand the audits previously performed by quality improvement organizations (QIOs);
- Comprehensive Error Rate Testing (CERT) auditors, who identify areas where high error rates occur and analyze data from specific providers to determine if the provider is billing in error;
- Zoned Program Integrity Contractors (ZPICs), auditors with broad powers that extend to Medicare managed care and Medicaid claims.

(For details on the RAC audit program, see *Hospital Case Management*, November 2008, cover.)

"Hospitals are going to be subjected to intensive scrutiny from a number of directions on a pre-payment and post-payment basis. In the past, only the quality improvement organizations conducted reviews as a small part of their responsibilities. Now, hospitals will be challenged to give rigorous attention to making sure that patients are admitted to the appropriate level of care and that the documentation in the medical record supports the appropriateness of services received," says **Deborah Hale**, CSS, president of Administrative Consultant Services LLC, a Shawnee, OK, consulting firm.

All of the new auditing programs are slated to be in place throughout the country by January 2010, adds **Brian Flood**, CHC, CIG, Esq., managing director for KPMG LLP and a former member of the oversight committee for CMS.

"Having all of these implemented at roughly the same time will have a cumulative effect on the health care industry and provide a challenge for hospitals to mitigate their risks through documentation, make it more difficult to know who's asking for what records, and it will increase the importance of conducting a parallel internal review to keep track of and anticipate the potential findings of regulatory auditors," he says.

The auditors are expected to share findings of improper payments, waste, abuse, and fraud with each other, Flood points out.

"Every time one of them identifies an area that contains error rates, they are mandated to share the information, so it is likely that all of them will zero in on common areas. Providers will have to discuss error issues with several sets of auditors," Flood says.

As these programs roll out, case managers should pay more attention than ever before to Medicare patients, their admission status, length of stay, and documentation of the patient's diagnosis in the medical record, Hale suggests.

"In many hospitals, case managers have big caseloads that make it impossible for them to do everything, so they concentrate on patients with commercial insurance coverage, which requires daily phoned updates, and don't have time for Medicare reviews. Sometimes attention to the medical necessity of admission does not get the full attention of a case manager that it needs. The case managers' focus should be to get out in front of the process so they can monitor level-of-care orders by the physicians and take steps to make sure they are accurate at the point of entry," Hale says.

The auditors likely will concentrate on cases assigned to high-weighted DRGs and with short lengths of stays and low charges, which may suggest that the MS-DRG was upcoded, Hale says.

In addition, cases assigned to MS-DRGs representing signs and symptoms have repeatedly been found to represent medically unnecessary cases according to the Hospital Payment Monitoring Program reports, she says.

In the case of patients who are admitted with symptoms such as chest pain or weakness, when a medical work-up does not establish a definitive diagnosis, the result is assignment to a MS-DRG that reflects only the sign or symptom, Hale says.

"It is the position of CMS that, in most instances, these patients should not be formally admitted," she says.

Bigger burden on CM department

The new audits likely will result in a bigger burden on case management departments that already are challenged to help their hospitals comply with other CMS regulations, including monitoring the present-on-admission indicators

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and tracking an increased number of core measures and other quality data, Hale says.

"Case managers can't do everything. In many hospitals, there is an increased need for bed availability, which means that in addition to coordinating care and reviewing documentation, case managers must concentrate on throughput issues. They are getting overwhelmed," she says.

One of the mandates of the ZPICs is to examine individual medical records to ensure that the beneficiaries are properly enrolled in Medicare or Medicaid, Flood says.

"Hospitals have typically used the paperwork they have, rather than making sure that the eligibility determinations were properly documented. Now, they are more at risk for loss of revenue. Hospitals are going to have to increase administration costs and check all paperwork so they don't suffer losses," he says.

CMS awarded contracts to four permanent Recovery Audit Contractors in the fall and is gradually rolling out the program.

The goal of the RAC program is to identify improper payments made on the claims of health care services provided to Medicare beneficiaries. Some health care providers may begin receiving requests for medical records or a letter requesting that an overpayment be repaid as early as this month.

The permanent RACS will be paid on a contingency fee basis on both the overpayments and underpayments they find.

The RACs will hold "town hall" meetings in each state with health care providers and CMS staff and representatives from the RACs.

CMS is transitioning responsibility for reviewing hospital claims to determine the appropriate payment due and prevent or reduce improper payment from the QIOs to the fiscal intermediaries (FIs) and, ultimately, to seven MACs, which will be responsible for large regions, rather than just one state, Hale says.

QIQs focus changed

This will allow the QIOs to concentrate on improving patient quality of care and maintaining quality improvement and provider assistance efforts, according to CMS.

Unlike the QIOs, which performed only post-payment reviews, the FIs and MACs can perform medical review on a prepayment or post-payment basis.

In the past, the FIs primarily were responsible for auditing and making sure improper payments were not made for outpatient and skilled nursing facility services and did not have jurisdiction over the inpatient setting. It was the QIO's responsibility to determine if inpatient hospitals placed patients in the right MS-DRG and if admissions were medically necessary, Hale says.

The MACs will pay both inpatient and outpatient bills as well as professional fees and will be responsible for auditing all three for improper payments, fraud, and abuse, Hale points out.

This change may help hospitals in their efforts to assure that physician documentation is complete and accurate, she says.

"Up until this point, physician payment was made by a carrier. Hospitals were frustrated because if an admission was denied because it didn't meet medical necessity, the hospital payment was denied but the physician still got paid. Now, the physician payment may also be denied if the documentation in the medical record doesn't support the care provided," Hale adds.

The RACs were allowed to look at physician claims in the demonstration project but, as a rule, didn't look at many, since the hospital payments represent a bigger dollar amount and they were receiving a percentage of the improper claims they discovered, Hale points out.

For the first time ever, MACs can conduct prebilling reviews, Hale says. This means that instead of getting the explanation of benefits that comes back with the check, hospitals will receive a request for medical records.

"The hospitals won't know if the chart will be reviewed until they submit the bill," she says.

Medicare has declared that there should be a three-month window between the implementation of the RAC and the MACs so hospitals won't get hit with both at the same time, Hale says.

Unlike the MACs and RACs, which concentrate on fee-for-service Medicare claims, the ZPICs will review all providers of Medicare and Medicaid services, including managed Medicare and Medicaid, Flood says.

The ZPIC program was created early this year and implemented July 1, 2008. The ZPIC program replaces the Program Safeguard Contractors created in 2006 to look for fraud and abuse, Flood says.

The Zone Program Integrity Contractors are private contractors who will work in the same geographic areas as the MACs. The ZPIC program is being rolled out from the West Coast to Mississippi starting this month. It should be in

place throughout the country some time in 2009.

"The MACs are intended to take a team approach with providers. They review appropriateness of payment, ask for documentation, and educate the providers. From what I can tell, the ZPICs are going to act more as enforcers and regulators," Flood adds.

The scope of work for the RACs is fairly contained within standard fee-for-service billing, and they are limited to one year for medical utilization. The ZPICs have an extraordinarily wide scope of work with no limits, he adds.

The ZPICs have a legal staff, a medical director, a coding staff, a nursing staff, auditors, and investigators.

According to the CMS Statement of Work, the ZPICs will perform investigations; refer cases to law enforcement; make coverage and coding determinations; review audit, settlement, and reimbursement of cost reports; review bids for participation in the prescription drug program; assist CMS in developing a list of entities that may require future monitoring based on past history; conduct specified audits; conduct specified complaint investigations for Part C and D; conduct preliminary investigation into entities conducting fraudulent enrollment; eligibility determination and benefit distribution; match and analyze Medicare and Medicaid data; and coordinate potential fraud, waste, and abuse activities with the appropriate MMEs and complaint screening for Part C and Part D.

According to CMS, the ZPICs are authorized to perform pre-pay medical review, post-pay medical review, medical review in support of benefit integrity, provider notification and feedback, coordination with the staff at the MAC, and program integrity management reporting.

In addition, Medicare's CERT contractors began reviewing hospital claims, looking for high error rates, for the first time in April.

In the past, the CERTs never looked at inpatient claims but now they can pull samples of hospital records, Hale says.

The CERT methodology includes selection of a sample of claims, requesting medical records from providers who submitted the claims, and reviewing the claims and medical records for compliance with Medicare coverage, coding, and billing rules.

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Documentation program helps avoid revenue loss

Physician education, standardized prompts key

When the Centers for Medicare & Medicaid Services (CMS) unveiled the new MS-DRG reimbursement system in 2007, a data analysis projected that Sharp Chula Vista Medical Center was likely to lose about $500,000 with the new system, based on the hospital's 2006 data.

After a series of initiatives to improve documentation and capture of complications/comorbidities (CCs) and major complications/comorbidities (MCCs), the 330-bed hospital in suburban San Diego actually experienced an additional $2 million in revenue.

The hospital advisory board conducted an analysis of the new MS-DRG system, which showed that the hospital was likely to take a financial hit when the new reimbursement system was implemented if changes weren't made, says **Cheri Graham-Clark**, RN, MSN, PHN, director of quality improvement and care management/patient safety officer.

Sharp began its MS-DRG initiative as soon as CMS announced the new reimbursement system.

Projects included an extensive education program for physicians, including packets of information for each service line, standardized query forms for physicians, and the addition of a clinical documentation specialist position to the staff, says **Susan Payne**, RN, BSN, CPHQ, CPUM, manager, case management/social services. The clinical documentation specialists report to the manager of case management.

The hospital appointed an MS-DRG committee that worked with the physician advisor to case management, the health information management manager, and the manager of care management to develop ways to educate the physicians.

Educational materials created

The team created a story board that they shared at a physician expo, wrote articles for the physician newsletter, and developed a PowerPoint presentation and educational information specifically for each service line. The physician advisor provided a continuing medical education program to the medical staff as well.

The team created a "little green book" of about

80 pages that fits into a lab coat. The book includes information on the MS-DRGs, CCs, MCCs, documentation requirements, length of stays for specific diagnoses, and InterQual criteria for medical necessity, including the difference between criteria for the intensive care unit and telemetry vs. medical-surgical admissions and acute inpatient admission criteria vs. observation status criteria.

"We have 1,000 printed and handed them out at clinical service meetings and the physician expo. In addition, the case managers and the physician advisor hand them out when they interact with the physicians," Payne says.

The MS-DRG team created a library of about 30 concurrent query forms that are used by the clinical documentation specialists to query the doctors on documentation.

The majority of the forms were developed following a systemwide analysis of the hospital's most common MS-DRGs, MCCs, and CCs, and others were added based on physician interaction, Payne says.

Physicians on the hospital's utilization review committee and medical directors for the service lines had input into the development of the concurrent query forms.

The forms include definitions, such as what body mass index indicates what type of obesity, and the clinical definitions for sepsis, along with a check-off box.

They provide information for the physicians but do not coach them on what to document, Payne adds.

For instance, the heart failure form says the physician has documented that the patient has heart failure but more specific information is needed. The query form also includes clinical definitions of various types of heart failure and a check-off box. The physician simply answers the query by placing a mark in the relevant check box and signing the document.

The forms are a permanent part of the chart.

"We leave the forms in the charts in hopes that the physicians will include the information in the discharge summary so the information will be easily available in case of a recovery audit contractor [RAC] audit," Graham-Clark says.

Early on, the hospital determined that it would need additional staff to handle documentation enhancement and created the position of clinical documentation specialist, which is shared by two people.

Payne and the lead case managers handled the MS-DRG documentation program from Oct. 1 to Feb. 1, when the new clinical documentation specialists came on board.

One is an RN case manager who is in charge of clinical documentation at another hospital. The other is a foreign-trained physician with a case management background who is bilingual.

The clinical documentation specialists went through intensive training on documentation enhancement and coding and meet regularly with the coders to identify areas where they can improve.

When the clinical documentation specialists conduct daily concurrent review of the charts, they look at laboratory values, vital signs, and other clinical information in addition to physician dictation, orders, and progress notes, identifying opportunities for more specific documentation.

They query the physicians, either by using the concurrent query forms or connecting with them in person, and educate them about the documentation that is needed as well as looking for specific educational opportunities.

For instance, they worked with the emergency associates (EAs) — physicians who work as hospitalists who manage the care of unfunded patients and those without an admitting physician.

"We targeted these first because they have a contract that pays them based on the DRG payment, so accurate documentation is vital to assigning the correct DRG for their patients. Length of stay is also very important to them," Payne says.

The department tracks the physician prompt forms on a spreadsheet by type and by volume to identify educational opportunities.

Their efforts are backed by staff experts, such as the hospital's diabetic nurse practitioner who reviews the charts of diabetic patients. Their goal is to review how the patient's documentation is documented (controlled vs. uncontrolled) and to review how complications such as diabetic neuropathy are documented.

Focus on wound documentation

The wound documentation nurse also works with the clinical documentation specialist to ensure that wounds are appropriately documented.

The wound documentation process is a part of the hospital's efforts to ensure that all conditions that are present on admission are documented.

"We did an analysis to identify where there is risk for not being in compliance with the 'present-on-admission' requirements and determined

that wounds are our biggest risk," Payne says.

The committee moved wound consultations to the front of the chart so they will be immediately visible when the chart is reviewed.

"The case managers check to make sure any wounds have been identified, especially if the patient is coming from a skilled nursing facility or another hospital," she says.

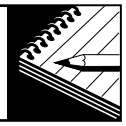
The emergency department case manager is a member of the clinical documentation committee team and works with the emergency department physicians and staff to make sure that all conditions that are present on admission are documented.

If nursing documents that a patient has a wound on admission, the clinical documentation specialist completes a wound-staging concurrent query form. The physician is asked to document the wound stage and signify whether it was present on admission.

Sharp Corporate Compliance works in collaboration with the clinical documentation process and participates in the monthly meetings with the clinical documentation specialists and coders to assure compliance with coding guidelines and MS-DRG documentation requirements, and to ensure that the concurrent queries do not lead or coach the physicians in their documentation.

*(For more information, contact **Susan Payne**, RN, BSN, CPHQ, CPUM, manager, case management/social services, e-mail: Susan.Payne@sharp.com.)* ■

GUEST COLUMN



Discharging patients with behavioral disorders

Post-hospital follow-up is an important part

By **Madeleine Y. Gomez**, PhD
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For professionals working in health care, it is easy to quickly become accustomed to the various presentations and stressors that accompany a patient who requires hospitalization. In fact, our efficient functioning is dependent on this to some degree.

However, this should never allow us to become comfortable or callous to the experience that the patient and his/her family are going through as well as to the importance of delivering care that supports the continuity of treatment and the coordination of care among the treating team.

When coordinating the care of patients with psychiatric disorders, either as a primary or secondary diagnosis, hospital case managers should keep in mind from the beginning that a transition to the community will be more difficult for these patients than for many others. They should take steps to ensure that the patients follow their treatment plan and avoid coming back to the hospital. It is through those efforts and compassion that we affect quality care, alleviate suffering, and support mental health and progress.

A psychiatric hospitalization never is a small matter. The acute symptomatology that precipitates and renders necessary a mental health inpatient admission are of significance. The patient may be capable of self-harm or harm toward others. Similarly, patients may be incapable of taking care of themselves or have suffered an exacerbation of a mental disorder or progression of that disease that meets the medico-legal criteria for inpatient admission. The hospitalization focuses on stabilizing the acute symptoms and comprises only a small portion of the whole and ongoing treatment of the patient.

Services also should be delivered with optimal consideration given to the rights of the patient to be treated within the least restrictive setting to ameliorate or stabilize the presenting problem.[1]

Ongoing awareness of this framework will lead us to appropriate goals for this level of care and, most importantly, post-discharge recommendations.

For the patient, the mere process of being admitted to the hospital will add stress upon the challenges of the current mental dysfunction requiring treatment in a restrictive setting. If it is a first hospitalization for the individual, the stresses may even be greater than for those who already have gone through the process.

For the family of the patient, there will be stresses as well. If this is an initial engagement with the mental health system, these stresses could be significant and upsetting to all. For those families who have been through the psychiatric hospitalization of a loved one in the past, the response may be one of the following: indifference, attempts at continued

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CRITICAL PATH NETWORK™

EMR triggers, concurrent review help hospital scores

Automation, checks and balances are part of the process

A series of initiatives, including automatic triggers for quality measures in the hospital's electronic medical record and concurrent review by case managers for core measures, has resulted in significant increases in quality measure scores at Russellville (AL) Hospital, a 100-bed facility.

For instance, the rate of acute myocardial infarction (AMI) patients prescribed a beta-blocker at discharge rose to 100% from 83.3%, and the rate of AMI patients receiving a beta-blocker at arrival rose to 100% from 80% from the first quarter of 2006 through the second quarter of 2007.

During the same time period, the rate of patients with pneumonia receiving the pneumonia vaccine rose to 100% from 73.5%, and blood cultures performed in the emergency department prior to initial antibiotic increased from 83.3% to 100%.

Surgical patients who received a prophylactic antibiotic within one hour prior to surgical incision increased to 91.7%from 76.7%.

Automation critical

"We tried to build in as much automation for recommended care as possible and to include a lot of checks and balances in the system," says **Pamela Welborn**, RN, CPUR, director of case management, medical records, and quality, who began the initiative when the case management department combined with medical records and quality in 2006.

A key component of the initiatives is the hospital's electronic medical record, which is fully functional and allows communications between all disciplines.

"It really helps when we want to discuss the record with someone in another department. They can pull the record up, rather than having to come to the floor and pull up the chart," she says.

CM duties

Case managers cover the hospital from 6 a.m. to 6 p.m. Monday through Friday and alternate being on call during night and evening hours and on weekends.

Three of the four case managers are responsible for utilization review, care coordination, discharge planning, and other social work issues. They are assigned by unit and physician and manage the care of an average of 15 patients a day.

The fourth case manager is the quality case manager and monitors readmissions and mortality and conducts reviews of procedures outside the operating room and operating room procedures.

Welborn handles all the validation and internal review for core measures.

At Russellville Hospital, the nursing assessment includes an automatic trigger for a case management consult whenever a patient is admitted with pneumonia, congestive heart failure, or a possible acute myocardial infarction.

This triggers the case managers to monitor the patient's chart and conduct concurrent review for core measures.

For instance, when a patient is admitted with congestive heart failure and the case manager receives the trigger, he or she determines if the patient has had the required echocardiogram. If

so, she prints it off and places it in the paper record for the physician to see. If the patient's left ventricular function is below 40%, the case manager reminds the physician to address this condition with appropriate treatment, such as an ACE inhibitor or angiotensin receptor blocker.

"Since the case managers also are discharge planners, they follow these patients through the continuum and ensure that the physician has addressed the continuing medication needs, such as being discharged on an ACE inhibitor," Wellborn says.

Ensuring vaccines are given

To ensure that appropriate patients receive the influenza and pneumonia vaccines, the nursing assessment in the electronic medical records includes a place for the RN to assess if the patient has had the vaccines.

If the nurse fails to do so, the case managers are automatically alerted and conduct the assessment when they make their daily rounds with the physicians.

"We receive a daily printout showing what patients haven't received the vaccines. When the case managers round with the physicians, they remind the doctors that the patients may benefit from the vaccine and talk to the patients about receiving the vaccine," Welborn says.

If the patient says he or she doesn't want the vaccine, the case manager can document the patient's refusal in the progress notes.

The medical record has automated discharge instructions for congestive heart failure and smoking cessation instructions. If the patient doesn't have congestive heart failure or doesn't smoke, the nurse just omits those instructions.

"This helps us ensure that the patients who need this information get it. The nurse doesn't have to remember to print the information out. It automatically is included in the discharge information," Welborn says.

The electronic medical record also includes triggers for a pharmacy review.

For instance, when a patient comes in with pneumonia, the pharmacy department receives a trigger that prompts the pharmacist to check the admitting order to ascertain appropriate antibiotic selection. The pharmacy receives a similar trigger for surgical patients.

If the recommended prophylaxis has not been ordered, the pharmacist contacts the physicians.

In addition, the hospital's care paths incorporate core measures evidence-based medical treatment.

"The emergency room staff knows to pull the care paths for these patients and to follow them, ensuring that the patients receive all the recommended treatments and procedures in the specified time frames," Welborn says.

The hospital, in conjunction with the medical staff, has developed preprinted orders for pneumonia and congestive heart failure that include the recommended prophylaxis for both ICU and non-ICU admissions.

"Since these are administered through the emergency department, we have utilized an extensive collaborative program with the emergency room physicians to ensure that the orders are used," Welborn says.

With input from the medical staff, the hospital has developed venous thromboembolism (VTE) protocol for total knee replacement surgery and total hip replacement surgery and built as many of the Surgical Care Improvement Project (SCIP) measures as possible into the physician's preoperative and postoperative orders.

The protocol includes postoperative orders for T.E.D. anti-embolism hose and sequential compression pumps as well as a check box for physicians to prescribe the appropriate medications to aid in prevention of VTE.

"To meet the SCIP requirements, patients have to receive the prophylaxis within 24 hours of the surgical close time. Our medical record automatically triggers a time for the medication to be administered according to the order," she says.

In addition to concurrent review by case managers for quality measures, Welborn reviews every patient on every quality measure and conducts a thorough review to determine the reasons why the recommended care wasn't followed.

She pulls a daily report from the medical record that shows any patient who has not received the care recommended in the core measures and drills down to find the cause and the person responsible.

For instance, if a blood culture isn't ordered or a prophylactic antibiotic isn't utilized for a pneumonia patient, she often finds that there is an opportunity to educate new staff or physicians.

If the omission is related to nursing knowledge, she generates a quality variance form and sends it to the manager of the nurse responsible. The manager educates the nurse on the importance of following the core measures guidelines.

"When the occasional problem does occur, it usually is related to medications being administered outside the recommended time frame or when the

nurse fails to document the use of T.E.D. hose or sequential compression pumps," she says.

*(For more information, contact **Pamela Welborn**, RN, CPUR, director of case management, medical records, and quality, Russellville Hospital, e-mail: Pamela.Welborn@lpnt.net.)* ■

Easing transition from hospital to LTAC

Education of families, physicians one key to success

Faced with capacity challenges, the case management department at Harris Methodist Hospital in Ft. Worth, TX, is collaborating with representatives from local long-term acute care hospitals (LTACs) to develop ways to improve transitions of care from one facility to another.

"Our capacity is a constant challenge. In 2007, we were at 99.7% capacity. One of our goals is to get patients who no longer require acute care into the best level of care, helping us serve the most acutely ill patients. We want to make sure that the transition occurs in a timely fashion and in a safe manner and that all the stakeholders are satisfied with the transition of care," says **Mari J. Finley**, RN, MBA, director of medical management.

The LTAC Community Collaborative committee, which meets twice a year, includes physicians, RN case managers, and social workers from the hospital and liaisons from the long-term acute care hospitals, who represent a multitude of disciplines including RNs, social workers, and speech therapists.

"We wanted to open dialogue with representatives of the LTACs and work on ways to make discharging our patients to the LTACs as easy as possible for everyone involved. As we move forward, we plan to expand the committee to include other physicians as well as members of the community," Finley says.

The team is working to develop a best practice model for discharging and transitioning patients from acute care to post-acute care and to create outcomes metrics to measure progress in each step. The National Transitions of Care Coalition standards have been extremely helpful to the group, Finley says. *(Editor's note: For information on NTOCC, see their web site at www.ntocc.org.)*

The committee has put together a visual patient-centered model that focuses on the stages of transition and what should happen during each. The transition points include the assessment to determine LTAC appropriateness, communication to the family; physician order, LTAC referral, consulting/attending physician agreement, payer notification, family choice/agreement, transportation, and arrival at the LTAC.

Educating physicians, patients

"Our goals include moving the patients through the continuum as quickly as possible, providing tools to facilitate the discharge process and care transitions for patients and families, and educating our physicians to understand the kind of services that long-term acute care hospitals can provide and which patients are appropriate for discharge to an LTAC," Finley says.

Physicians don't completely understand the criteria for discharge to an LTAC, Finley says, adding "we are working to help the physicians feel comfortable in transitioning their patients to another level of care sooner, rather than later."

Since LTACs are relatively new to the Fort Worth area, many families do not completely understand the services they provide and the difference in LTACs and other levels of care, Finley adds.

"We are working to educate them on the advantages of LTACs and how they differ from skilled nursing facilities and the acute care hospital. LTACs provide a lot of the same treatment as an acute care hospital and they do it very well," she says.

The committee's work already is paying off, Finley says.

The collaborative work sessions have helped educate everyone on the committee about the difference in services provided by an acute care hospital and an LTAC, the special services that each LTAC in the Fort Worth area can provide, and what is involved in transferring the patients between facilities, she adds.

"By working with the LTAC representatives on the committee, our case managers and social workers better understand the special skill sets at each individual facility, which in turn, helps us determine which patients are most appropriate to transfer to which facility," Finley says.

The hospital's case managers and social workers have developed a closer relationship with the LTAC staff, facilitating the handoff of patients, she says.

"We have communication and dialogue that didn't happen before. In the past, they'd get a referral and they'd come and do their thing and we'd do our thing without much collaboration," Finley says.

Transportation issues have been identified as major barriers to a smooth and timely transition of patients between the hospital and the LTAC, Finley says.

"Many times, by the time we get the discharge order, it's late in the day and transportation to the LTAC can't be arranged until the evening. This may create problems for the LTAC," she says.

The committee has put together a spreadsheet of each transportation service in the community, including hours of operation and capabilities.

For instance, the city's ordinance requires that patients who need intensive medical oversight must be transported by a firm with an emergency medical service license.

"Transportation has been one of our barriers. This chart helps our staff choose a company that is available and is capable of transporting a particular patient. This way, we can transition patients in a timely manner as soon as the discharge orders are written, rather than having to wait until the next day," Finley says.

Harris Methodist Fort Worth has a unit-based model of case management, with case managers and social workers collaborating on each unit. The case managers have a caseload of about 30 patients and are responsible for leading the team. They oversee the clinical utilization management reviews and review the clinical criteria to help direct the social worker into the appropriate level of care following discharge.

When a physician makes an order for an LTAC assessment, the case manager and social worker communicate with the patient and family about the referral and discuss the reason for the referral in easy-to-understand language. They give the family the expected transfer date and help them understand how the process will move forward and what role they will have in the transfer.

They work with the LTAC liaisons who come to the facility to assess whether the patient is appropriate for their facilities and collaborate with them to facilitate the transfers.

If the patient is appropriate for transfer to more than one facility, the family visits the facility and chooses the one they prefer.

"We work with the physicians to communicate the family's decision and whether or not the LTAC can accept the patient. Then the physician makes the discharge decision. Our acute care physicians may not practice in the LTAC setting so they have to have a comfort level with transferring their patients," Finley explains.

When the physician order is written, the case managers contact the insurance company for approval. They work with the social workers to help find funding for the unfunded patients. For instance, some LTACs don't accept Texas Medicaid.

When the patient is ready for discharge, the case managers arrange for transportation, based on patient needs, and fill out the paperwork for transfer.

The hospital is getting an electronic referral system that is expected to reduce the turnaround time from the time the patient is referred to the time the LTACs accept the transfer.

"We are working to improve the time it takes to get the patient transferred from the hospital to the LTAC once the discharge is planned. It's a slow process, but we're making progress," Finley says.

*(For more information, contact **Mari J. Finley**, RN, MBA, director of medical management, Harris Methodist Hospital, e-mail: Mari.Finley@texashealth.org.)* ■

Medicare clarifies medical privacy of health info

MLN Matters, published by the U.S. Department of Health and Human Services (HHS), provides clarification about the Privacy Rule of HIPAA, when transferring private health information to potential post-acute providers:

- Discharge planners do not need to obtain signed consent forms from patients before sharing their medical information for treatment purposes.
- HHS adopted modifications to the rule in August 2002, which clarify that incidental disclosures do not violate the Privacy Rule when providers have commonsense policies that reasonably safeguard and appropriately limit how protected health information is used and disclosed.
- Doctors and other providers, including discharge planners, can share needed information with patients' families, friends, or anyone else identified by patients as involved in their care as long as the patient agrees. ■

(Continued from page 182)

support and involvement, or abandonment.

As the hospital treatment team seeks to stabilize the patient for treatment in the next level of care, awareness of the family as a potential resource and support will be integral in the care of the patient. It is estimated that 65% of psychiatrically hospitalized patients will return to their families.[2]

Families who demonstrate support and are involved will be easier to identify and work with during the process of the hospitalization, but it will likely be useful to attempt to engage distant, indifferent, or abandoning families who may provide positive support in the process and continuing treatment of the patient's disorder. As such, the family is a central resource in continuity and coordination.[3]

Addressing families' needs

With current and ongoing shrinking health care resources, the family's position, perceptions, and support may be even more important than ever in mental health caregiving today. These familial needs must be addressed.[4]

Patients should leave the hospital with a clear plan for follow-up care, including appointments with mental health providers who will follow them over the long term.

Since hospitalization is geared toward stabilizing the patient to return to the community, it is possible that the patient may have progressed but does not fully understand the continuing treatment plan or the importance of aftercare. Often, the treatment plan and the follow-up appointments amount to little more than some pieces of paper and a couple of prescriptions in a plastic bag along with other papers generated during the hospital stay.

Although it is not a new concept, the importance of discharge planning from the day of admission cannot be overstated.[5] This includes ensuring that the patient has set follow-up appointments with mental health providers so he or she can continue the progress that commenced during the psychiatric hospitalization as well as reducing recidivism and the potential for rapid readmission.

Follow-up appointments for psychiatric medical management as well as psychotherapy are important to support the patient's treatment and stability.

Case managers should educate the patients on the importance of follow-up and help them understand that the role of the hospital stay was to stabilize their condition but does not represent the bulk of the treatment they need.

The importance of medication compliance should similarly be underlined. Whenever possible, include the family in these discussions as they often will have a bird's-eye view of the patient's functioning.

Ideally, patients should sign consent forms during the inpatient stay authorizing release of information needed in order to coordinate between treatment teams as patients transition from an inpatient to an outpatient setting. However, those signatures for informed consent, which will authorize the communication necessary between providers for a unified team effort, also can be gathered at the outpatient follow-up appointment.

Not obtaining the requisite forms for release of information creates barriers to quality coordination of care. While patients do have a right to refuse to sign these releases, case managers have an opportunity during the hospital stay to educate the patients about the importance of the releases for the communication and coordination of the team. If it makes sense to the patient and the confidentiality of the case is reinforced, compliance can often be attained. At the same time, requisition of records can ensue. Requisition of records can be time-consuming and tedious but can result in a wealth of data, which can directly affect treatment planning as well as understanding the patient.

As discharged psychiatric patients often will leave with medication prescriptions for psychotropics, coordination with the primary care physician will be paramount to aid medication coordination and to minimize the potential of cross-medication interactions.

In addition, there are cases where patients' primary care physicians are prescribing a psychotropic medication, which the patient may be abusing or could use to attempt suicide. Communication regarding those interactions and potential pitfalls results in improved quality of care and a more unified treatment plan while reducing the possibility of the patient splitting the treatment team. Similarly, encouraging both patient and family support of the recommended medication regime is integral to the continuing care.

Collaborative care must integrate mental health with primary medical care.[6] Despite releases of information, professionals often have a barrage of excuses for not making the time to discuss the case and the planning inherent in the process.

Professionals should make the effort to take

12 steps to discharging mental health patients

1. Educate the patient and family regarding the importance of ongoing care and follow-up appointments.
2. Have set appointments for medication management and psychotherapy in place at discharge.
3. Include the family in the planning whenever possible.
4. Communicate with the primary care physician regarding the treatment plan and medication regime.
5. Ensure that patients sign the release of information for coordination of care and communication between the team of treating professionals.
6. Obtain requisition records and a thorough history for review by treating professionals.
7. Develop safety plans for the patient, including education regarding acute symptoms that require action.
8. Recommend home intervention support if available, especially for patients who have been previously noncompliant.
9. Consider maintaining the same treatment team whenever possible across levels of care or for repeated hospitalizations.
10. Identify the case manager as the repository for data, coordination between the team and ongoing treatment planning.
11. Utilize all available support systems, including family, community, and health care.
12. Create an outpatient treatment plan that includes as patient appropriate: identification of triggers, warning symptoms, anniversary reactions, support of medication management and psychotherapy, identification and reduction of violence, improving coping, relaxation exercises, expanding social support, healthy choices, and positive expressions of anger/anger management and empowerment of the patient. ■

advantage of communication any time the release of information has been achieved. Examples are easily found of treatment team members actually working at odds against each other's treatment plan without awareness of the attempts of the other professional. This must be avoided; it is the patient who will suffer the consequences for this lack of coordination of care.

If an option for post-acute case management is available and appropriate, hospital case managers should recommend it in their discharge plan and communicate with the case manager who will be working with the patient after discharge. Communication with this individual can help coordinate the efforts, cross-communications, and urgent alerts that are a part of treating cases with post-hospitalization issues and pathologies.

As case managers who coordinate care after discharge for patients with mental disorders, we have found that offering a transitional care visit in the home as well as ongoing home intervention-based therapy has a positive impact on the seven-day follow-up rate as well as the reduction of readmissions.[7]

Results from the program evaluation demonstrated that behavioral health admission rates in a Medicaid managed care sample decreased an average of 2.5 admissions, a reduction of 86%, following the implementation of home-based services.[8]

While those interventions require a specialized team of individuals well versed in psychiatric in-home treatment, the positive results are supported by statistics in recent publications and recently have been recognized by URAC, which awarded PsycHealth Ltd. with the Gold Award for Healthcare Management in 2008.

Documentation and transmission of a good history as opposed to a cursory one gathered initially during the hospitalization will form the basis for the best treatment recommendations. This will not only aid the current presentation but also reduce the need for duplicating efforts during subsequent interventions.

A well-known saying in mental health is that "unless you have spoken with more than one person regarding the history, what you have is just a story." This is not to devalue the patient's perceptions of his/her life experiences and feeling but rather to more fully understand, from a variety of perspectives, what that experience has been as clearly as possible. This will be of particular support in approaching patients who are psychotic or delusional as without these data, it can be hard to discern what comprises reality for the patient. Speaking to the family is likely to provide a fuller and potentially clearer picture of the identified patient.

Family also can be of great support as they are often in the position of being able to observe the patient's symptoms and can quickly report whether the patient is doing better, worse, or about the same. They offer a unique and ongoing bird's-eye view of the patient, which can utilized with the patient's report for ongoing recommendations.

The importance of case managers emphasizing

support for concurrent psychotherapy cannot be understated. Medications may effectively stabilize brain imbalances, but changing habits and relationships, increasing coping, reducing violence, and choosing healthy practices are more likely to improve through the process of individual psychotherapy as well as family therapy.

Maintaining the same treatment team from the hospital to outpatient treatment should be recommended when it is possible. If this is not possible, it is helpful if the same team is reassigned for subsequent hospitalizations and that the patient is referred to the same outpatient providers after discharge.

This continuity helps to reduce repetitive efforts and putting the patient through the stresses of having to form all new relationships at each level and entry into care.

It should be noted, however, if the patient is not improving, the family is dissatisfied, or the patient requests reassignment, changing treating providers should ensue or be assessed.

Despite ever-shrinking health care resources, it remains incumbent upon health care professionals to provide the best quality of care, especially for those individuals with psychiatric disorders who have had the need for hospitalization. We should be aware of both our feelings and those of the patient and avoid a hardened and unempathetic stance. By doing this and facilitating coordination between professionals, the patient, and the family and endorsing the discharge plan and continuity of ongoing psychiatric care, we can best practice and support those who come to us in need.

*(For more information, contact **Madeleine Y. Gomez**, PhD, president, PsycHealth Ltd., Evanston, IL. E-mail: mygomez@psychealthltd.com.)*

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CNE *questions*

21. In addition to the Recovery Audit Contractors, hospitals soon will be audited by Medicare Administrative Contractors, Comprehensive Error Rate Testing auditors, and Zoned Program Integrity Contractors as part of the CMS initiative to combat fraud and abuse. When are the programs slated to be in place?
A. July 2009
B. October 2009
C. January 2010
D. April 2010

22. The Zoned Program Integrity Contractors will examine individual medical records to ensure that patients are properly enrolled in Medicare.
A. True
B. False

23. How much money in additional revenue was generated by Sharp Chula-Vista's documentation improvement projects?
A. $2 million
B. $500,000
C. $1 million
D. $1.5 million

24. It is important in working with hospitalized psychiatric patients that you have them sign a release of information.
A. True
B. False

Answer key: 21. C; 22. A; 23. A; 24. A.

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. **The semester ends with this issue.** You must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

7. Gomez MY. Home intervention: An idea whose time has come again. *Case in Point* June/July 2007; 41-44.
8. Johns M, Gomez MY, Flaxman, J, et al. Psychotherapeutic home intervention program: Impact on Medicaid readmission rates. *Care Manag J* 2007; 8(4):179-186. ■

AMBULATORY CARE
QUARTERLY

IP oversight required: If NV leads, will nation follow?

'Half-dozen' clinic laws under discussion

Proposed state laws in Nevada in the wake of a highly publicized hepatitis C outbreak in Las Vegas include proposals to hire infection preventionists (IPs) as consultants to oversee practice in freestanding clinics.

"It's possible that we could have that sort of requirement within the state of Nevada," says **Brian Labus**, MPH, a lead investigator in the case for the Southern Nevada Health District in Las Vegas. "We have had those sorts of discussions with the [state] Legislative Committee on Healthcare. Our legislature meets every other year and they will be meeting again in the spring of 2009."

With another recent HCV outbreak reported in a North Carolina cardiology practice, there is growing sentiment that something must be done to beef up infection prevention oversight in ambulatory care. Whether it involves IPs or some other approach such as increased health department inspections, the aftermath of the Vegas outbreak is expected to set the tone — and, possibly, the legislative model — for the rest of the nation.

"Nevada must be in the forefront," says **William Schaffner**, MD, chairman of the department of preventive medicine at the Vanderbilt University School of Medicine in Nashville, TN. "They are grappling not only with what happened in the past, but dealing with this going forward. They might be in a position to instruct us all."

A "half-dozen" bills are being drafted in Nevada for consideration at the legislative session, but the specifics are still being hammered out, Labus notes. "Something needs to be done after our large outbreak here," he says. "We're hoping it could serve as a model for other communities. At this point, we will have to see how the legislature wants to move on it. There will be a lot of discussion. [The involvement of IPs] is something that was discussed, and it is a strong possibility for the upcoming session."

The outbreak resulted in the largest look-back investigation in medical history, with some 50,000 patients seen at two endoscopy clinics advised to be tested for HCV, HIV, and hepatitis B. The practices under investigation in Nevada include alleged reuse of syringes and re-entry into single-dose vials of pain medication for different patients undergoing colonoscopies. "We have nine HCV cases that we can link to the clinic, and we have 77 cases that are possibly linked," Labus says. "Of those nine, eight are at the main facility and one is at the other location."

Latest count

The latest count of confirmed HCV cases adds one from the previous reports of eight patients, he clarifies. Investigators have completed genetic testing and are confident in reporting the nine cases, but previous reports of HIV transmission are being dismissed. A reported 11 HIV cases that have been identified are being ascribed to prior infections rather than clinic treatment, he says. "We have no HIV or hepatitis B transmissions related to the clinic," he says.

IPs and public health officials have warned for years that ambulatory settings and physician offices were flying under the radar when it comes to infection prevention. Bolstering the claim, a series of incidents has occurred with disturbing regularity. Last year, a physician anesthesiologist in Long Island was investigated by the

New York State Department of Health for allegedly reusing syringes to draw up medicine from multidose vials. The department contacted approximately 8,500 patients who had been treated by the physician prior to Jan. 15, 2005, urging them to be tested for hepatitis and HIV. In recent years, large outbreaks of HBV and HCV infections have occurred among patients in private medical practices, pain clinics, endoscopy clinics, and a hematology/oncology practice.[1] Even as the number of medical procedures performed in physician offices and clinics continues to increase, many of these settings operate with strikingly little regulatory oversight and expert consultation.

"Speaking generally, the vast majority have not developed a consultative relationship with anyone in infection control to come in and give them periodic guidance and oversight," Schaffner says.

Could there be similar bills elsewhere?

The legislative activity in Nevada could result in similar bills elsewhere, possibly opening up new consulting opportunities for IPs. "How to provide the oversight is something that needs to be debated at the national and state level," he says. "They could require these institutions for licensure to demonstrate that they have an association with some sort of infection control activity. Something that would do immediately is create a new industry of infection prevention consultants."

Indeed, hospital systems have turned to IPs for oversight of rapidly expanding networks of affiliated clinics. "I have over 80 clinics now; and a year from now, I will have over 100," says **Judie Bringhurst**, RN, BSN, CIC, an IP who oversees infection control in ambulatory settings at Duke University Medical Center in Durham, NC. "We are building by leaps and bounds."

With health care delivery rapidly moving beyond the hospital, it goes without saying that infection prevention activities must follow. "Ambulatory care has to change," she says. "If we can't do our duty to take care of our patients properly, somebody is going to have to make us do it. Duke insists on Joint Commission accreditation. Look at what happened in Las Vegas — my gosh, 50,000 people [advised to be tested]. I

CNE 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. ■

would hope some kind of regulation would result. But it has happened before, and nothing changed."

Reference

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HOSPITAL CASE MANAGEMENT™

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