HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

AHC Media LLC

IN THIS ISSUE

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ZPICs are the next, most aggressive layer of the CMS audit process

Short stays targeted in early investigations

If the experiences of the first hospitals targeted by the Zoned Program Integrity Contractors (ZPICs) are any indication, at some point this year, your hospital may receive a surprise visit from an investigator with a law enforcement background who will request medical records to be examined for possible waste, abuse, or fraud.

If your hospital can't defend the cases, the implications could go far beyond just paying back the reimbursement. Penalties may range from stiff fines to an investigation by the Department of Health and Human Services' Office of the Inspector General (OIG) or Department of Justice.

The ZPICs are another layer of scrutiny that the Centers for Medicare & Medicaid Services (CMS) has created in an effort to assure that hospitals and other providers are appropriately paid.

First, CMS established the Recovery Audit Contractors (RACs) to conduct a three-year pilot project and rolled the program out nationwide last year, followed by the Medicaid Integrity Contractors, which focus on Medicaid reimbursement.

CMS has established seven ZPIC zones, which conform to the Medicare Administrative Contractors (MAC) regions. The first ZPIC contractor hired by CMS, Health Integrity LLC, which received the contract for Zone 4 (Colorado, New Mexico, Oklahoma, and Texas), began pursuing investigations in mid-2009. The program is expected to be rolled out across the entire country by the end of this year.

The ZPICs are mining data and looking for patterns and trends that may look like fraud, says **Deborah Hale**, CCS, president of Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK.

"They have a lot of teeth, and hospitals that are targeted can experience a lot of anxiety and grief. This isn't just a matter of the hospital arguing to support medical necessity. If a hospital attracts the attention

of a ZPIC, it can face legal action," Hale adds.

The new Zoned Program Integrity Contractors are focusing on all aspects of Medicare, looking for waste, fraud, and abuse. The program's focus is starting with hospitals but eventually will include all providers of Medicare services.

Because they will be able to investigate all health care providers in a geographic region, they will be able to detect cross-billing and relationships between health care providers and to identify fraudulent activities between Medicare and Medicaid programs.

'Shift in the war on fraud'

Kim Brandt, director of the CMS Program Integrity Group, calls the ZPIC program "a major shift in the war on fraud."

The ZPICs are looking beyond merely recouping money that was improperly paid to the hospital, according to **Brian Flood**, managing director for KPMG LLC and a board member of the Health Care Compliance Association.

ZPICs are investigating the reason a hospital was overpaid and looking at hospital governance to determine if it's an institutional mistake or oversight, if it's a problem the institution is unable or unwilling to control, or if it's intentional conduct.

"When they show up at the door, they've already used an audit protocol to identify the records, and they have a reason to be there. They aren't just dropping by for a random visit," Flood says.

The rollout of the ZPIC program makes it more important than ever for hospitals to make sure up front that all patients admitted to the hospital are appropriate inpatient admissions, either meeting inpatient screening criteria or approved in writing by the UR committee physician advisor, Hale says.

Hospitals must have a knowledgeable gatekeeper on the premises 24 hours a day, seven days a week in order to avoid the prospect of paying back reimbursement or facing penalties, she adds.

More staff will be necessary

"It's no longer going to be enough to have cases reviewed for medical necessity within 24 hours or first thing Monday morning if the patients are admitted over the weekend. This presents a challenge for small hospitals, which may have to add staff or train existing staff to review just one admission during the night. It's going to mean more staff for the larger hospitals as well," Hale says.

The role of the case manager is absolutely essential in addressing the medical necessity of admissions and making sure the admission is appropriate, the admission order is clear, and the case is well documented, Hale says.

This means that hospitals are going to have to invest in the overhead necessary to hire

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knowledgeable staff that can assure that patient status is correct up front, Flood adds.

Otherwise, the cost to the hospital is likely to be far more than increasing staff, he adds.

If a hospital has a pattern that appears to be waste, abuse, or fraud, in addition to recouping the overpayment, the ZPIC program can assess penalties ranging from one to three times the amount of the overpayment. In addition, the situation will put the hospital on the ZPIC's radar, and it likely will be investigated again next year, Flood says.

If the errors appear to be egregious, the hospital may face scrutiny from theOIG or the Department of Justice, he adds.

"Hospital administrators are going to have to make the choice of increasing the case management staff and making sure the patient status is correct up front or spending 10 times as much on lawyers, accountants, and experts to defend itself. It's pay now or pay later," Flood says.

The early ZPIC investigations focused on short stays, going up to 72 hours, and patient status, Flood says.

Hale adds that among her clients, hospitals targeted by the ZPICs had a high volume of cardiovascular procedures and received requests for records of one-day and short-stay patients, primarily those with cardiovascular DRGs.

"These are not hospitals I would think of as being at risk for committing fraud," Hale says.

What sets the ZPICs apart from other auditors is their data mining, looking for patterns and trends that could be construed as fraud, Hale explains.

For instance, if a hospital had a high number of cases assigned to DRG 313 (chest pain) and the majority stayed just one day, it may appear that there is a pattern of admitting people with chest pain to inpatient status rather than ruling out a heart attack in the outpatient setting, she says.

However, the issue of medical necessity and the importance of getting it right is the same regardless of whether a RAC, a MAC, or a ZPIC is looking at the record, Hale points out.

"Hospitals have got to get it right the first time. They need a process for assuring that the patient status is correct and that the admission order is complete and a utilization review process that includes physician input to address questions of medical necessity," Hale says.

Physician advisors should be knowledgeable about Medicare criteria and should be people who won't just rubber-stamp their peers' decisions, Hale says.

"Hospitals can have an on-site physician advisor or contract with someone at a remote location, but they must have a knowledgeable physician advisor to review cases when there is a question about medical necessity. Once the order for the inpatient admission is written, there isn't anything a hospital can do to change it without a physician advisor," she points out.

No playing with 44

Don't play around with Condition Code 44 rules, Hale admonishes.

"Case managers should never try to change inpatient status to outpatient without going through the formal utilization review process," she says.

In addition to making sure that their medical records are complete and well documented, hospitals should take steps to be prepared when a ZPIC investigator arrives, Flood suggests.

"My experience with the ZPICs is that they are very aggressive. These inspectors are going to be asking very pointed questions with the mission of finding waste, abuse, or fraud and reporting it to CMS, the OIG, or the Department of Justice. They are paid a contract rate plus an award for positive performance, and they have an incentive to dig as deep as they can and uncover as much as they can," he says.

Hospitals already should have put together a team to respond to the RACs and MICs and can use the same team to respond to requests from the ZPICs, Flood suggests.

Develop policies and procedures outlining what is going to happen when the ZPIC investigator requests records, and designate someone to respond to the requests and work with the investigator, he adds.

Keep in mind that whoever is working with the investigators should leave a good impression and have the right approach, he says.

"Look for the skill set of who will be the best person to find out what the inspector really needs to get the job done. It should be someone who can put the hospital in the best light," he says.

Most of the inspectors hired by the ZPICs to visit the hospitals have a law enforcement background, Flood says.

"It's important for hospitals to keep in mind that the field investigators are not likely to have direct experience with the information they are collecting. However, they are going to write a

report with their impression of the interaction with the hospital staff. It's important for the hospital staff to help the inspectors get the information they need and leave with a positive impression," Flood says.

It's a good idea for the hospital to make sure that CMS gets comprehensive information even if the investigator asks for incomplete information, Flood says.

"Make sure CMS gets the entire picture and not just the piece the investigator requests. By helping an investigator get the information he needs, you are helping yourself," he adds.

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Hospital and SNFs collaborate on transitions

Continuity-of-care department spearheads effort

By working closely with a carefully chosen network of skilled nursing facilities, The Methodist Hospital in Houston has smoothed the transitions in care for patients being discharged to the facilities.

The hospital created a continuity of care department two years ago with the mission of improving the quality and safety of transitional care.

"I was a director of case management and social work for many years, and I know that all hospitals work very hard at making things go smoothly when we discharge patients, but the truth is, we don't know what happens after patients leave the hospital setting," says **Lynda Collins**, MSSW, LCSW, director of continuity of care at the 900-bed hospital.

Sometimes patients and post-acute agencies have the perception that hospitals are just dumping their patients, she says.

"I know this is wrong, but it seems to patients and community agencies that we just discharge patients with no help. I felt that we needed to make formal connections to those places where we discharge the patients," she says.

The department was organized partly in response to a throughput problem, which often led to patients being held in the emergency department or the post-acute anesthesia care unit when there were no acute care beds available.

"We had patients who were ready to move to the next level of care but were still in the hospital. We know that patients in the emergency department or the PACU are definitely sicker than patients at the end of their stay. We needed to find out why the patients were staying when they were ready to be discharged," she says.

The hospital created an advisory council that includes Collins, a geriatrician, a PhD nurse with many years of experience in the long-term care arena, two managers from the case management department, and an operational vice president of nursing.

SNF horror stories

Collins and her team analyzed the throughput issue to determine the reason that patients were staying when they were ready to be discharged.

With almost 90 skilled nursing facilities in the area, the team knew that the problem was not a capacity issue.

"What we found was a hesitation on the part of the physicians to refer patients to a skilled nursing facility and a lot of reluctance among patients and family members to leave the hospital for a skilled nursing facility. They had heard a lot of SNF horror stories," she says.

The team looked for ways to address concerns about quality and to address the fact that some patients are harder to place than others. They wanted a way to educate the physicians and families that skilled nursing facilities can provide the kind of care that some patients need.

"I know from personal experience that when the time comes for a loved one to go to a skilled nursing facility, it's difficult even though you know it's the right thing to do," she says.

The hospital invited about 150 skilled nursing facilities in Harris County and the surrounding counties to come to a meeting.

"We let them know that we were going to affiliate with a small number of skilled nursing facilities that were interested in working closely with us to make sure the transition was smooth and safe, that the patients received high-quality care and didn't bounce back to the hospital," she says.

A combination of two or more members of the advisory council visited every skilled nursing facility before they were accepted into the network and researched quality data and other

information about the facilities before signing them up.

SNF network created

The hospital ultimately signed an affiliation agreement with 26 skilled nursing facilities, creating the Methodist Skilled Nursing Facility Network. The agreement says both sides will work together to improve care and ensure a smooth transition.

The network met frequently in the first year of the program and now meets quarterly.

"We got a lot of feedback from the skilled nursing facility representatives, and we learned a lot about some things we could do better on our end. The SNFs agreed to take patients six days a week and for longer hours. We offered clinical education for the staff at each facility and, because of the size of the hospital, they knew they would get a high volume of patients," she says.

The arrangement has been a win-win proposition for all involved, Collins says.

The hospital now sends more patients to the SNFs in the network than in the past and the SNFs make the decision to accept patients more quickly.

"Our physicians are more comfortable because they know that we are monitoring the quality at these facilities and we don't lose sight of the patients we send there," she says.

At the outset, the team worked with representatives from the skilled nursing facilities to determine what kind of information the receiving facilities want when a patient is transferred.

They developed a new easy-to-read transfer form based on the information the facilities said they needed. Collins is working with the hospital's information technology department to develop a way to transmit the form electronically.

"When we talked with representatives from the SNFs, they talked about the problems they face such as what happens if a patient comes late in the day or if the facility doesn't have complete clinical information. We learned a lot about the impact on the patient's transition if we don't do everything on our end to give them the information they need," she says.

The facilities in the network have assigned a clinical liaison so that staff have one person to work with when patients are transferred. Many of the facilities send the liaison to the hospital to assess the patients and collect the clinical information.

"They give us a lot of attention and respond very quickly," she says.

In the past, the skilled nursing facilities sometimes sent patients back to the emergency department if the clinical picture wasn't what they expected.

For instance, in the past, the staff would fax over clinical information and lab values, but sometimes patients developed other symptoms before they arrived at the SNF or the lab values changed.

Now, the SNFs have contact information for the patients' nursing unit and Collins so they can work through the issues without bringing the patient back.

"We want to do the right thing for the patients, but moving them back and forth is not the best way to handle any problems that arise. In the past, nobody's job was to look at the overall picture. Now we can answer questions and address things without having to move the patient back," she says.

The hospital has created a web-based map with the locations of all 26 facilities. Case managers can use the map to show the families facilities in their neighborhood so they can visit before making a choice.

"The feedback from our patients and the SNFs has been very positive. This program has benefited everyone," she says.

(For more information, contact: ***Lynda Collins****, MSSW, LCSW, director of continuity of care, The Methodist Hospital, Houston, e-mail: LCollins@tmhs.org.)* ■

Nonadherent patients may not understand

Keep your message easy to comprehend

When patients don't follow their discharge instructions and end up back in the hospital, it may be that they simply don't understand what they were supposed to do at home.

"Today's health care professionals are busy and give the discharge information quickly without making sure that the patient gets it. Patients want to do what they need to do to get better. When they are noncompliant, it may be that they just don't understand," says **Gloria Mayer**, RN, EdD, CEO for the Institute for Healthcare

Advancement based in LaHabra, CA.

People who are discharged from the hospital are still really sick and have a difficult time learning and remembering a lot of material, adds **Helen Osborne**, MEd, OTR/L, president of Health Literacy Consulting, a Natick, MA, firm.

"That's why case managers must make sure that patients and family members understand what they should do after discharge and why it's important," she adds.

Keep jargon to minimum

Medical professionals tend to use medical jargon when they speak to patients, which creates a tremendous health care literacy problem, Mayer says.

"When patients aren't familiar with the terminology the case manager uses, they miss the message and they don't understand what they need to do, so that translates into nonadherence," she says.

For instance, people who are told they have "hypertension" sometimes think that means they are hyperactive, but they may understand the term "high blood pressure."

Instead of using terms such as "myocardial infarction," use "heart attack" and say "X-ray" instead of "radiology," Mayer suggests.

When you talk to patients, avoid medical jargon and technical terms you don't need to use, Osborne suggests.

"On the other hand, case managers have a responsibility to use the correct word when it's needed and explain it clearly," she says.

For instance, words such as "chemotherapy" or "dialysis" are complicated words, but there are times when people need to know what they mean, Osborne adds.

Remember that idiomatic terms such as "draw your blood" may not be understood by people who are new to the language.

Confirming understanding is an essential step in communication and one that often gets left out, Osborne says.

Teach patients as clearly and simply as you can, and ask open-ended questions on key points to make sure that they understand, she says.

Using the teach-back technique is key in ensuring that your patients understand what they should do when they leave the hospital, Osborne says.

"We as health professionals do our best to use plain language, but doing that alone is not sufficient. We need to make sure our message is understood," she says.

When you talk to your patients and their family members, create a feeling of partnership. Use phrases such as, "I want to make sure we're on the same page," or "Let's work together to make sure you do everything you need to do after discharge."

Assess your patients' comprehension after you give them key points or new information.

Always ask open-ended questions, putting the responsibility for comprehension on you. Say, "I want to make sure I've given you the right information."

Don't say, "Do you understand?" because the only answer is yes.

Narrow your focus when you ask questions, Osborne suggests. For instance, say, "The doctor said you need to be on a high-fiber diet. When you go grocery shopping, which cereals would you buy?"

After the patient and family members repeat what you've told them, reinforce that they have the information correct, or correct it if their answer indicates that they don't understand, Osborne says.

Try different strategies and ways of learning, such as bringing in pictures or giving examples, she says.

"If you find the person really does not understand, try to determine why they are having so much trouble. Is the issue hearing, language, anxiety, or learning skills? Think of alternate ways to teach the patient. Make another appointment and invite the family members to participate or arrange for a few visits from a home care nurse who can reinforce the teaching," she says.

Keep it short on topics

Remember that patients can absorb only two or three things at a time. If multiple items need to be covered, break them into small portions, Mayer suggests.

"If people are sick, they are even less likely to understand everything you are telling them," she adds.

Limit your teaching to three concepts at a time and include the family whenever possible, Mayer suggests.

"If medication is the most important thing, teach them about medication. If they need a follow-up appointment, write down the name and

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CRITICAL PATH NETWORK™

Communication ensures patients are safe post-discharge

Provide timely information to next level of care

Whether patients are being discharged from the hospital to home, another level of care, or transferred to the care of another health care provider, communication is crucial to ensure a safe discharge or transition, says **Hussein Tahan**, DNSc, MSN, RN, CNA, executive director, international health services at New York Presbyterian Hospital in New York City.

"Good communication among all the parties involved in patient care within and outside of the hospital is a key component to ensuring a smooth and safe transition of care. Case managers need to make sure that communication is effective, whether it's between members of the treatment team, the patient and family or caregiver, the payer, or anyone else who is involved directly or indirectly in the care of the patient," he says.

Any communications between the hospital and clinicians or caregivers at other levels of care also should be documented in the medical record, Tahan says.

Tahan, a member of the National Transitions of Care Coalition convened by the Case Management Society of America, helped come up with a model for communication during transitions of care as patients move through the health care continuum. **(See model on p. 40.)**

Successful communication means that an accountable clinician transmits accurate and complete information in an easy-to-understand form in a timely manner to the proper person at the next level of care, and ensures that the person receives the information and understands it, he says.

Key information must include a summary of what happened at the hospital and what needs to happen post-discharge as well as medications, treatment regimens, results of tests, allergies, personal preferences, status of advance directives, and insurance benefits, Tahan adds.

This means that the person who assumes care of the patient after discharge from the hospital has all the information he or she needs to maintain continuity and consistency in care and to make sure that nothing falls through the cracks, he notes.

"The information should be put together in a clear and concise way that is direct and to the point to allow the clinician at the next level of care to understand why it is being shared and what to do with it, especially as the patient's care transitions to those at the next level of care. Such communication enhances continuity of care and prevents unnecessary readmissions to the hospital," he says.

For instance, the post-acute facility, the home health agency, or the family member caring for the patient needs to know about follow-up appointments and if there are tests or procedures that weren't appropriate in the hospital setting that need to be completed after discharge, he adds.

In the hospital setting, the clinician responsible for communicating with the next level of care is likely to be the case manager.

"In fact, the case manager is the best person suited to assume such a role. As they work with the treatment team and manage patient care activities, case managers almost always are involved in transition of care activities. This means they are a strategic player in preventing medical errors and other problems that can occur with the handoffs of care between care settings

and when providers are not managed effectively or properly," Tahan explains.

The person receiving the care-related information may be a case manager at another facility, a physician in the community, a home care nurse, or the patient's caregiver in the home setting, he adds.

Case managers must ensure that the information necessary for effective patient care goes to a specific accountable person at the next level of care who can communicate the information to the rest of the care team, Tahan says.

"In the past, the case manager might have faxed whole or parts of the medical record to the skilled nursing facility but didn't necessarily follow up to make sure the right person got the information or that he or she received it in a timely manner and was aware of how to use such information. Today, direct communication between providers of care at transferring and receiving facilities is a necessity to ensure safe and effective transitions and care outcomes," he says.

CMs, social workers liaisons

At North Hills Hospital, the case managers and social workers are responsible for communicating with the liaison at the next level of care and making sure that pertinent pieces of the medical record accompany patients to the next level of care, says **Cynthia Lawson**, RN-BC, MBA, CPHQ, director of case management at North Hills (TX) Hospital.

If the patient is going to a skilled nursing facility, long-term acute care hospital, or another institution, the staff make sure that the most recent progress notes, the orders, and any reports from a consultant also accompany the patient to the receiving facility.

"The receiving facility should have a complete picture of patients' conditions when they arrived at the hospital as well as what happened immediately prior to them being transferred," Lawson says.

In addition, the primary care nurses communicate with their counterparts at the post-acute facility just as if it were a shift handoff, she says.

"Most of the post-acute providers who work with us have liaisons who come to the facility to assess the patients and collect their own information, but that doesn't eliminate the need for the nurse-to-nurse report," she says.

If patients are going home with home care, the case managers make sure the home care agency has the history and physical and a reconciled medication list, as well as the doctor's orders, she says.

"Many patients are cared for by hospitalists instead of their community-based physician during their hospital stay. This means the community physician often has no idea what happened during the hospital stay or what kind of follow-up care the patient needs," Tahan says.

Hospitals need to develop ways to communicate with primary care physicians after their patients are hospitalized to inform them about what follow-up needs to be done after discharge, he adds.

Make sure that the patient's primary care physician gets a discharge summary quickly so he or she will be prepared when the patient comes in for a follow-up visit, suggests **Beverly Cunningham**, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital and health care consultant and partner in Case Management Concepts LLC.

"In addition, the primary care physician needs to know what was prescribed (medication, tests, treatments) for the patient in the hospital so he or she won't end up repeating the same or be unaware of

Four Types of Patient Transitions

- **The transition of patients within settings in one provider organization.** This may be a transition from the intensive care unit to a bed on a regular unit or from the emergency department to the ICU within the same hospital.
- **Transition between settings from one organization to another.** This includes patients moving from a hospital to a subacute setting or skilled nursing facility or from an ambulatory care clinic to a hospital setting.
- **Transition across health states.** This is when patients move from one care setting to another to meet their care needs as their health conditions or interests change. For example, moving from assisted living to a skilled nursing home or from acute care to a hospital or palliative care.
- **Transition between providers,** such as a transition from a primary care physician to a specialty physician — for instance, from an internist to a cardiologist or surgeon.

Source: Hussein Tahan, DNSc, MSN, RN, CNA, New York Presbyterian Hospital, New York City.

certain important nuances in the care of the patient to maintain safety and prevent deterioration of the patient's condition," Tahan says.

Information may be faxed, mailed, or sent electronically to the community physician, but someone on the team must be accountable for seeing that it is communicated to the proper person at the physician practice and that it is clear and understood, he says.

Case managers should communicate with the patient and family and encourage them to actively participate in the decisions about the next level of care, Tahan says.

"Patients need to know where they are going, and when, what is going to happen at the next level of care, and they must be in agreement for the discharge to succeed," he says.

Patients are in the hospital such a short period of time and it's often hard to catch up with the family, Cunningham points out.

"We have to look for windows of opportunity and adjust the way we communicate, such as e-mailing the family members," she says.

Let your patients know what to expect when they get home and what symptoms to watch for that indicate they should call the doctor, says Cunningham.

Make them aware that they need to follow up with their primary care physician within a week or so and, if possible, help them make an appointment before they are discharged.

At North Hills Hospital, if the patient is going home with home health services, the home health liaison visits the patient's room, explains the services, and how things are going to work.

"It's also a benefit to the patients to help them understand what is coming next and minimizes their apprehension about post-acute care," Lawson says.

Educate your physicians on the need for patients who go home without services to have referral for home care so a nurse can reinforce the discharge planning and make sure the patient can manage at home, Cunningham adds.

Medication reconciliation is an important part of ensuring that patients safely transition to another level of care, Tahan adds.

Case managers need to make sure that patients understand how and when to take their medication. They need to be aware of whether they should keep taking the medication they were taking before they were hospitalized or substitute another medication prescribed during their hospital stay, he adds.

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Hospital provides DM to employee groups

Reduces hospital stays, ED visits, and absenteeism

Mission Hospital in Asheville, NC, has teamed up with seven employers in the community to provide face-to-face disease management for chronically ill employees.

The program helps participants stay healthy, reduces hospital stays and emergency department visits, cuts down on absenteeism, and saves money for the self-funded employee health plans, according to **Anna Garrett**, PharmD, manager of outpatient clinical pharmacy programs for Mission Hospital.

The program grew out of the Asheville Project, which started as a pilot project conducted by the North Carolina Association of Pharmacists to help people with diabetes adhere to their treatment plan.

"The program has morphed into a broader model of care that is offered by the hospital to employers with self-funded employee health plans," Garrett says.

Hospital-based care managers, usually either pharmacists or RN-certified diabetes educators, work one on one with employees with chronic conditions that include diabetes, hypertension, high cholesterol, asthma, and depression.

The program is voluntary. The health plans agree to pay for medication and supplies and any copay the employees are responsible for as long as they are in the program. The hospital bills for the care manager visits through the employer's third-party administrator.

People who enroll in the program agree to attend self-management classes covered by their company's health plan and meet face to face on a

regular basis with their care manager.

In the first five years of the program, the overall cost of care for participants with diabetes and asthma dropped by $2,000 a year, and costs for participants with cardiovascular disease decreased by about $900 a year, Garrett says.

At the same time, absenteeism decreased dramatically among employees receiving disease management, she adds. In the original pilot project, the 48 people with diabetes employed by the City of Asheville cut their sick days in half, reducing them from an average of 12 days a year to six.

Identifying eligible members

The hospital arranges with the employer's pharmacy benefit management to run a report determining which employees are taking medication for the chronic conditions covered by the program. Once they are identified as eligible for the program, the hospital sends them an enrollment package with information about the program.

"We don't want to violate HIPAA regulations by making the employer aware of an employee's health condition without permission from the employee," she says.

Employees who enroll are assigned a care manager based on their diagnosis and the complexity of their needs.

For instance, those who are taking multiple medications are assigned to a pharmacist care manager. Employees with diabetes work with the nurse care managers who are certified diabetes educators. A physician assistant coordinates care for the depression patients if depression is their only diagnosis.

Participants meet face to face with their care manager a minimum of once a month or as often as four times a month, depending on their clinical situation.

The majority of participants meet with their care manager at the hospital. Some are given paid time off to participate. Other employers give their employees unpaid time off to see the case manager. Still others require the employees to see their care manager when they aren't scheduled to work.

"We have almost zero no-shows among employees who come during working hours and get paid for it," she says.

A care manager goes to one worksite two days a week to work with the employees.

"At this site, the employees work 12-hour shifts, which make it difficult for them to come to the hospital during business hours. This arrangement has worked out well, and we are working with other employees to provide more on-site disease management. Some of the participants are reluctant because they would have to change care managers and end a long-standing relationship," Garrett says.

The care managers notify the participants' physicians about the program and their patients' participation and work with them to ensure that the treatment plan is being followed. They contact the physician if there is a change in the patient's condition or if they think a change in medication could be beneficial.

"The care managers do a lot of education and coaching and work with the employees to set goals and develop strategies for managing their condition," Garrett says.

They monitor medication adherence and side effects, helping patients understand their treatment plan, and helping them set goals, which may include exercise, diet, or smoking cessation.

The program is open-ended, and employees may participate for as long as they like.

"Some people have been in the program for as long as 12 years. They love it. It's a great benefit for them, and the cost reduction to the employers has been sustained over the long term," Garrett says.

The care managers are employed by the hospital and have undergone training to learn how to work with patients with chronic diseases. The hospital has offered depression management training as part of continuing education.

In addition to being a care manager for the patients in the program, the nurses conduct diabetes education classes and work with patients referred by the hospital who need regular diabetes care.

The pharmacists also conduct medication consultations for senior citizens and medication reconciliation for surgical patients.

Garrett attributes the success of the program to the personal working relationship that develops between the care managers and the employees.

"We always see the patients in person. We find that face-to-face contact makes a huge difference in the outcomes," she says.

*(For more information, contact: **Anna Garrett**, PharmD, manager, outpatient clinical pharmacy programs, Mission Hospital, Asheville, NC, e-mail: Anna.Garrett@msj.org.)* ■

(Continued from page 38)

telephone number of the doctor and be very specific. Tell them to call Monday and see the doctor within a week," Mayer says.

Be specific with your instructions, she says.

For instance, with congestive heart failure patients, go beyond saying, "Weigh yourself every day," because weight can vary depending on the time of day and what the patient is wearing.

Say, "Weigh yourself when you get up in the morning before you put on your clothes."

Make sure that your written instructions are simple and legible. Keep in mind that people who are just learning to read English may not recognize script and print the instructions, Mayer suggests.

Most health education materials are written between the eighth grade and college level, and about 90 million Americans read at the fifth-grade level or below, Mayer says.

Don't use pharmaceutical company handouts. They tend to be far too complicated for the average person to understand, she adds.

Mayer suggests that hospital case managers review the materials they are handing out and make sure they are simple and to the point so every client can understand them.

"Some people argue that college-educated patients would be insulted by easy-to-read materials, but in fact, nobody ever complains that something is too easy to understand," she says. ■

RESOURCES

- For more information on health literacy in general, including links to articles, see www.healthliteracy.com.
- To download free podcasts about health literacy, see www.healthliteracyoutloud.com.
- For more information on health literacy and easy-to-read "What to Do for Health" books, visit www.iha4health.org.
- To find out more about Health Literacy Month in October, see www.healthliteracymonth.org.
- To download the free guide, "Health Literacy and Plain Language" or to find out more about health literacy products, see www.healthliteracyinnovations.com.
- The Institute for Healthcare Advancement is hosting its Ninth Annual Health Literacy Conference, a continuing education conference for professionals, May 6-7 at the Hyatt Regency Hotel in Irvine, CA. For more information, visit www.iha4health.org.

Revamped documentation program raises CMI

Additional staff, training were keys to success

In just four months after the launch of an intensive compliance documentation management program (CDMP) Bon Secours St. Francis Health System's Medicare case mix index increased significantly.

"Any time we can get an improvement in the case mix index, it is significant from a reimbursement standpoint as well as correctly reporting the severity level of our patient population. This is good for the hospital as well as for the individual physicians," says **James T. Jones**, PhD, RN, administrative director case management and patient documentation for the Greenville, SC, health system.

The hospital redesigned its compliance documentation management program, expanding its staff by 60% and provided intensive training in documentation assurance to the CDMP nurses and medical staff before rolling out the program last September.

"The original team already was making an impact to the bottom line, but we felt like we could do better with more staff and a different model," Jones says.

Jones developed a business plan and a return-on-investment estimate and got approval to add more staff to the program and to convert one of the compliance documentation management nurses' job to a supervisory position.

Before the redesign, the compliance documentation management nurses were assigned geographically and typically covered more than one unit.

"This was really stretching them too thin. The goal was to get 75% penetration; but in reality, they had time to review only 50% to 55% of the charts," Jones says.

The compliance documentation management nurses now are assigned by service line and cover an average of about 30 beds.

"Before we redesigned the program, we had one nurse covering 50 to 60 beds. By reducing the caseload, we've increased the success of the program," he says.

The nurses are salaried and typically work Monday through Friday from 8 a.m. to 4:30 p.m. The CDMP staff do not cover weekends, but Jones anticipates that may change in the future.

The nurses all have cell phones and are available after hours if a physician has questions related to documentation.

They attend the monthly meeting of the service line medical staff and adjust their schedule accordingly.

The additional staff were hired after an extensive search to identify nurses whose background and experience matched the service line they were going to review.

Matching staff by service line

"We spent a lot of time matching the background of the nurses to the specialty they cover so they already will know what to look for and where the gaps are likely to occur. To do it any other way would be a disservice not only to the hospital, but to the nurse and the physician," Jones says.

For instance, the oncology compliance documentation manager is a nurse practitioner who no longer wanted to be in a practice setting but wanted to keep her focus on oncology.

"She is a perfect fit. The oncologists have a tremendous amount of respect for her because she is so knowledgeable about oncology. It's a tough specialty with new treatments coming along every day, and she is familiar with them," Jones says.

Before the program was launched, the nurses all completed an intensive, weeklong, 40-hour compliance documentation management "boot camp" webinar developed by a vendor. After 30 days of studying the materials from the course, they were eligible to take a four-hour certification exam, Jones says.

All of the St. Francis nurses passed the exam the first time.

"When the nurses get through with the boot camp, they have a strong working base of the MS-DRG system, how comorbidities affect coding, what the documentation should be, and what to look for when they review the charts," Jones says.

The nurses use documentation software that includes a decision tree for determining the working DRG. The physician queries are built into the hospital's electronic medical record and show up any time the physician signs into the system.

"The query is right there in front of the physician and he can answer it electronically. The process is much smoother than when we had a paper system," Jones says.

Since the new program began, the nurses' query rates have increased significantly.

As the program was rolled out, the hospital provided extensive education to the medical staff on how ensuring accurate documentation will affect them in the future.

"We've done extensive education with the medical staff in large groups, in small groups, and one on one. We met with our entire hospitalist group to explain the goal of the program and how it helps the hospital as well as the doctors. We have tremendous support from the medical staff now that they understand what we are trying to do," he says.

Most physicians don't understand that insurance companies use MedPar data to help them choose their physician panels, Jones points out.

"If physicians don't document accurately in the medical record, it may appear that their patients are not as sick as those treated by their colleagues, but they have a longer length of stay. This can affect their relationship with insurers. In addition, consumers are becoming more health care-savvy and using web sites that compare one hospital or one physician against another," he says.

The CMDP supervisor attended all the medical staff meetings in September and October and introduced the nurses who would be working with the physicians. She gave a short presentation about the program, the goals, and how it will benefit the physicians as well as the hospital.

"We pointed out that if the language isn't correct in the documentation, the case will code to a lower-paying DRG, and the hospital won't get paid for the services it provides the patient. We emphasize that this is not upcoding. We're trying to make sure that the hospital gets the most appropriate reimbursement for the care we give the patient," Jones says.

The compliance documentation management nurses attend the regular service line staff meetings and educate the physicians on their roles and how they will affect physician practices.

"The physician meetings are the perfect opportunity for the CDMP nurses to clear up any issues regarding documentation and to answer any questions the physicians may have," Jones says.

The nurses review the query list every month and identify any patterns in documentation and opportunities for improvement and discuss them at the meeting.

In addition, the CDMP supervisor has identified

all the MS-DRGs that might possibly apply to each service line. During each meeting, the nurses focus on educating the physicians about documentation of three or four MS-DRGs and answer any questions.

"Over a six-month period, the nurses and physicians discuss all the DRGs relative to that specialty," he says.

Since the program began, the physicians have begun seeking out the CDMP nurses to make sure that their documentation is complete and correct, Jones says.

"The physicians don't know all the rules and regulations for coding. The purpose of this program is to coach and educate them on the proper terminology," he says.

The compliance documentation management program was born out of necessity because of Medicare and its reimbursement rules, Jones says.

"If the coders don't see specific language in the progress notes, they can't code correctly. Our nurses drill down and get very detailed in assuring that the doctors write the necessary information in the chart so it can be accurately coded," he says.

For instance, a physician may be treating a patient for pneumonia and the clinical data may support the diagnosis, but if the physician doesn't write the word "pneumonia" on the chart, the coder has to code the case as a simple upper respiratory infection, Jones says.

The initial goal of the program is to review 100% of all Medicare records and to slowly add other payers that base reimbursement on the MS-DRG system.

"We started out where we could have the most effect. Our goal is to be reviewing all payers by April 1. We want to be able to honestly say that we are reviewing all patients the same way regardless of payer source. It may not affect payment from commercial insurers, but we will feel the satisfaction of treating all patients the same," Jones says.

Jones anticipates that the education they are providing to the physicians on Medicare compliance will enable the CDMP nurses to handle all of the patients on the unit.

"The query rate should drop as a result of all the work they are doing, and we'll be able to add other payer sources without additional staff," he says.

*(For more information, contact: **James T. Jones**, PhD, RN, administrative director, case management and patient documentation, Bon Secours St. Francis Health System, e-mail: Jim_jones@bshsi.org.)* ■

CNE *questions*

9. What is the targeted time for CMS to roll out its Zoned Program Integrity Contractor (ZPIC) program?
A. Mid-2010
B. End of 2010
C. Oct. 1, 2010
D. Mid-2011

10. The Methodist Skilled Nursing Facility Network is a collaboration between The Methodist Hospital in Houston and how many skilled nursing facilities?
A. 90
B. 150
C. 26
D. 38

11. According to Gloria Mayer, RN, EdD, CEO for the Institute for Healthcare Advancement, discharge education should be broken into small segments that patients can grasp at one time. How many items should a case manager cover in each educational session?
A. Two to three
B. Three to four
C. Four to five
D. Six to eight

12. When Bon Secours St. Francis Health System redesigned its compliance documentation management program, it increased the documentation staff by what percentage?
A. 20%
B. 40%
C. 60%
D. 100%

Answer key: 9. B; 10. C; 11. A; 12. C.

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. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

ED decreases 4-hour wait times to 9 minutes

Rapid evaluation unit model most important driver

Not long ago, the ED at Palisades Medical Center in North Bergen, NJ, was struggling with waiting times hovering at about four hours.

"Like every other ED, we struggled with long waiting times — especially on the 3 to 11 shift," recalls **Maureen Coccaro**, MS, RN, one of two clinical coordinators of the ED. "If you had six people come in at once, with the old traditional approach it would take a nurse 10 minutes to triage each patient, so the last person to arrive would be waiting an hour."

The ED, which sees 35,000 patients a year, replaced that "traditional" approach with a rapid evaluation unit model. The results? Door-to-doc time is now at around nine minutes. "We still do triage, but we have brought it to the bedside," she explains. "That has freed up the front end."

When a patient first arrives at the ED, he or she now is met by a greeter, who is a clerk and will perform a quick registration. That registration gets the patient into the medical records system. The greeter then will bring the patient into the rapid evaluation unit and hand him or her off to a nurse. The patient is triaged at the bedside by a nurse, a physician's assistant, or a doctor.

"This gives us the opportunity to order whatever the patient needs then and there," Coccaro says. For example, there is no wait for the lab to pick up the blood. Lab work is sent via a newly installed pneumatic tube. **Gladys Sillero**, MSN, RN, CNS, APN-C, clinical nurse specialist and the other clinical director of the ED, says, "Some of our nurses' aides were educated in how to draw blood and they are nurse technicians now, so we can do bedside tests like glucose levels."

Coccaro says, "We can also discharge the patient with instructions more quickly, since we have a nurse both on the front end and at the back end." In spring 2008, the hospital started looking at processes and how the staff could better flow patients, Sillero says. She notes that hospital and ED leadership approved the hiring of a consultant to work with the ED.

In addition to the rapid evaluation model, says Sillero, the consultant recommended dividing the ED into two areas: one for walk-ins and low-acuity patients, and the other for those who required a full work-up. "The patients are usually admitted from that area," she explains.

Furthermore, the ED staff members have been communicating with the other departments about their work flow and how it affects the ED, Sillero says. "We've started doing morning rounds and getting together an interdisciplinary team to expedite care and discharge patients more quickly," she says. "I think it has helped a lot." Sillero says the team includes herself and Coccaro, a charge nurse, other nurses, physicians, physician assistants, ED techs, nurses' aides, a social worker, and a case manager.

While the ED staff agree that the installment of a rapid evaluation unit model was the major reason they were able to get door-to-doc times down to nine minutes, they note that smaller, less "glamorous" changes also made a significant contribution to their success.

For example, "We had just done over the back part of the ED to assist us with flow," says Coccaro. A discharge area was created and equipped with "stretcher-beds," a TV, and magazines so that patients waiting for X-rays or discharge instructions did not have to wait in the patient care area. Those beds could be used by new patients.

Coccaro says additional flow time was freed up with another simple change. "Before, every patient was brought in on a stretcher," she notes. "Now, they are brought in on a stretcher only when it's necessary. We have comfortable chairs for people with less serious illnesses or injuries to sit on."

When all patients were brought in on stretchers, they also were all put into hospital gowns, which took time, "and many patients do not need all that," she says. ■

Staff drive changes in LEAN process

No one likes change, and ED managers often face a tough challenge when introducing new processes to their staff. This resistance was not the case, however, during a successful LEAN initiative at Good Samaritan Hospital in Kearney, NE, because of the very nature of LEAN methodology.

"The staff came up with the solutions — physicians, nurses, communications, the telemetry tech, the lab, radiology, even the switchboard," says **Paul O'Connell**, RN, director of emergency services. "The team drove the solution, not administration."

Camil Saadi, the process improvement specialist who oversaw the initiative, says, "The best part of LEAN is that you start with a blank sheet of paper and determine which areas you should focus on to give you the most benefits from an efficiency and capacity standpoint. A high percentage of patients we see in the ED are admitted, so that factored into why we chose the ED."

O'Connell made a significant contribution to the success of the initiative, Saadi adds. "It makes a big difference how well the director is involved and willing to put in the effort needed," he explains.

The numbers don't lie, and having a handle on the numbers is a critical part of developing effective strategies for improving patient flow, says **Pamela Kiessling**, RN, MSN, director of patient flow & clinical integration, clinical & business integration, and patient services at Cincinnati Children's Hospital Medical Center.

"We knew that we were not as efficient as we could be with the whole process around discharges," she recalls. "For those who just needed antibiotics to take at home, for example, we did not plan in advance sufficiently to discharge them as soon as they were ready to go."

To improve in this area, you have to be able to predict discharges, she says. "The adult world has been doing this for a long time because of their payer structure. Pediatric facilities are paid differently [i.e., in terms of DRGs], so we have not been driven to be as proactive," Kiessling says. "But now we're doing it for the right reasons: to have the patients leave on time and have no delays."

Discharge prediction is a two-level process, Kiessling explains. First, the patient has to have discharge criteria. Goals need to be specific and well communicated to the entire team, including the patient and family. The second level of readiness has to do with the team tasks that need to be completed, such as home care arranged, prescriptions written, and orders written. "The goal is to have the team tasks completed prior to the patient's readiness for discharge whenever possible so that there is no delay for the patient once she or he is ready to go home," Kiessling explains.

Communication regarding the predicted discharge date and time is critical so that the entire team can execute the plan in a timely manner. For the ED, this timely discharge means a greater likelihood of a bed on the appropriate unit when it is needed and that any delay would be intentional and predictable and only to allow the right bed to be available.

In the absence of the ability to build new beds, Kiessling summarizes, timely discharge is a legitimate way to increase capacity in a hospital that operates with very few open beds at any given time.

In developing the predictive process, says Kiessling, "you have to build in the factor that you'll be wrong some percent of the time — anywhere from 20%-30% — not because you've not planned well, but because the child may not progress as well as you've planned." Still, she insists, "for any given unit, we can be right seven times out of 10." When planning for beds, then, you should look at your predictions and build in processes to account for the "unpredicted" beds that will be needed.

Where appropriate, you can write conditional

CNE objectives

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

- identify the particular clinical, administrative or regulatory issues related to the profession of case management
- describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the health care industry at large
- discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities. ■

COMING IN FUTURE MONTHS

- What you need to know to manage the care of older adults
- Discharge planning for hard-to-place patients
- Making sense of the new Condition Code 44 rules
- Tips for decreasing the length of stay

discharge orders, i.e., when the patients meet these criteria, they can go home, she says. These criteria must be patient-specific, Kiessling emphasizes. Discharge medication orders and discharge summaries are among the things that can be done ahead of time, she says.

At this point, says Kiessling, some units are 80% correct in their predictions, while others are closer to 50%.

At the same, says Kiessling, she began to look at how to predict admissions. "We have three kinds of admissions: scheduled, ED, and direct," she notes. "The trick is to know what's going on in the population you are looking at."

In January 2009, she says, a math formula was developed that allowed the ED to predict its admissions. The formula takes into consideration admissions from the ED "yesterday," "same day last week," "two weeks ago," "three weeks ago," and "four weeks ago," Kiessling says. These data are averaged. "We then look at trends for the last month in terms of percentage of ED visits admitted to the hospital and adjust accordingly," she notes.

"We are within 90%-95% accuracy most of the time," Kiessling reports. "Folks in my department and the ED clinical manager figured [the formula] out, and it's pretty good." ■