HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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Reimbursement changes coming– CMs key to meet payer requirements

Work with quality, physicians on deficits

When it comes to ensuring that patients are receiving high-value, cost-effective care, case managers are where the rubber hits the road, says Michael Taylor, MD, vice president of operations at Executive Health Resources, a Newton Square, PA, healthcare consulting firm.

"As the Centers for Medicare and Medicaid Services [CMS] and commercial payers shift from paying for volume to paying for value, case managers are going to have a very important role in helping their hospitals achieve correct reimbursement for services that are compliant with regulatory requirements," Taylor says. "From now on, hospitals are not going to be compensated just for how many services they provide but for the outcomes of those services. They are going to be responsible for the outcomes of the care they provide as well," Taylor says.

The changes in reimbursement create incentives for hospitals to improve care; however, in many cases, the stick is bigger than the carrot, and many hospitals are going to lose, Taylor says. "The programs are not designed so that if everybody does a better job they will do well," he says. "Hospitals literally have to outperform other hospitals in order to benefit. It's likely that there will be more financial penalties in the future for hospitals that have high utilization and spending patterns across the continuum." (For a look at the initiatives and how they work, see related article on p. 171.)

Change is on the way for hospital CMs

Hospital reimbursement as we know it is changing as the Centers for Medicare and Medicaid Services (CMS) rolls out new initiatives that base payments to hospitals on value as well as volume. In this issue of *Hospital Case Management*, we take a look at some of the changes that are coming down the pike and how they will affect case management. We'll give details on the value-based purchasing program, the initiative to reduce reimbursement for excess readmissions, and the new bundled-payment quality measure. We also offer tips for helping your hospital receive appropriate payment. It's all in this issue of *Hospital Case Management*!

The Inpatient Prospective Payment System final rule for 2012 is one of the first times that CMS has been so clear about how quality is going to affect reimbursement, says Beverly Cunningham, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital, and partner and consultant in Case Management Concepts in Dallas. "There are a lot of changes coming down the pike,"

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EXECUTIVE SUMMARY

Case managers can have a big impact their hospital's bottom line when the Centers for Medicare and Medicaid Services (CMS)begins rolling out initiatives that will reimburse hospitals for the value of the services they provide, in addition to volume.

- Start now to learn about the new reimbursement initiatives and work with quality staff and physicians to determine what issues need to be addressed.
- Take a proactive approach to discharges. Ensure patients understand their treatment plans and that there is a smooth transition to the next level of care.
- Hospitals with excess readmissions for heart failure, pneumonia, and acute myocardial infarction (AMI) will receive reduced reimbursement.
- Medicare will start tracking spending per-beneficiary for the entire episode of care, beginning three days before admission through 30 days after discharge.

Cunningham says. "It's important for case management leaders to understand that what case management does relates to the new reimbursement measures and how they affect the overall quality provided by the hospital. The bottom line is that these measures are simply doing the right thing for patients."

Taylor suggests that case management directors start by working with their hospital's internal quality department and engaging the physician staff as well. "There needs to be a combination of representatives from case management, quality, and the physician leadership who assess the different value-based purchasing measures and come up with a plan to address them," Taylor says.

Identify which patients are frequently readmitted and how much the hospital is spending on them, says Joanna Malcolm, RN, CCM, BSN, consulting manager, clinical advisory services for Pershing, Yoakley & Associates, a healthcare consulting firm in Atlanta. Look at how well they were ready for discharge, and determine where the deficits are in your educational process. she says.

Hospitals need to provide better education while patients are in the hospital and to start making follow-up calls after discharge to make sure the patients understand their treatment plan and are following the recommended regimen, Malcolm says. "Not only do hospitals have to make sure patients have a good discharge plan, that they understand their diagnosis, and what they should do when they get home; hospital case management must now extend into the patient's homes," she says.

Spend time with patients who are frequently admit-

ted and those who have newly diagnosed heart failure, Malcolm suggests. Make sure they understand their treatment plan, and find out if they have any questions. Build a relationship with your patients so they will learn to take care of themselves and stay out of the hospital, she says. "Often case managers don't follow up with patients to make sure they understand their treatment plan either because they don't have the time or they don't realize it is part of their job," Malcolm says.

A proactive approach to readmissions

In some cases, reducing readmissions hinges on patient adherence, Malcolm points out.

"If a heart failure patient doesn't take the medication or eats and drinks more than allowed, they're going to come back to the hospital," she says. "Unfortunately, hospitals are going to be penalized for patients' noncompliance."

Taylor predicts that in the future, hospitals might take more innovative approaches to reducing readmissions and optimizing post-acute care, such as increased use of telemedicine. "That hasn't happened yet largely because there has not been a clear financial incentive to do so," he says.

Case managers should work with the clinical nursing staff to develop check lists to make sure best practices and protocols are being followed, Taylor adds. For example, when a patient has joint replacement surgery, case managers could serve as an additional check to make sure that a physical therapist gets the patient out of bed and walking as soon as clinically appropriate. "It might not be obvious up front, but something as simple as early mobilization can sometimes affect the spending-per-beneficiary by possibly reducing the complications and the need for extensive outpatient therapy after discharge," Taylor says.

Look at how the hospital is performing now on CMS quality measures. Use physician and nurse resources to create a plan to address those issues. "Case management leadership should assess the department and create a plan to assess whatever deficits show up," Taylor says.

In case management departments in which utilization review staffs and care management staffs are different, both groups need to work together, he says. "All case managers need to work together, regardless of their assigned tasks. Value-based purchasing has both clinical and payment implications," Taylor says.

Malcolm cautions against giving case managers so many responsibilities they can't handle any of them adequately. Many times, jobs are assigned to the case managers because they're already in the record and are talking with patients, she points out.

"Case management directors need to make sure that case managers have the time to take the extra steps that are going to be required with the new reimbursement initiatives," Malcolm says. "When you start putting too much on people, they start sinking. Hospitals are going to need to consider increasing the number of staff and decreasing the case management caseload to the lower limits of the benchmark in order to make sure the staff has time to ensure the hospital is being paid appropriately." ■

Reimbursement changes are on the way

Medicare will pay for value, and volume

In a few years, hospital reimbursement is going to be a whole new ballgame as the Centers for Medicare and Medicaid Services (CMS) rolls out a plethora of changes in the way hospitals are paid, mandated by the Patient Protection and Accountable Care Act.

Hospitals will have a lot at stake as the new payment programs are rolled out, says Joanna Malcolm, RN, CCM, BSN, consulting manager, clinical advisory services for Pershing, Yoakley & Associates, a healthcare consulting firm in Atlanta. "It's going to be hard to stay on top of all the processes and performance measures on which they are going to be rated," Malcolm warns. "Case managers need to start looking at ways to get ahead of the game and to develop initiatives to improve quality and efficiency."

Beginning with discharges on or after Oct. 1, 2012, the Hospital Value-Based Purchasing program will use a complicated formula to reward or penalize hospitals for how well they perform. Michael Taylor, MD, vice president of operations at Executive Health Resources, a Newton Square, PA, healthcare consulting firm points out that the Value-Based Purchasing program is designed to be revenue neutral, which means it will be more of a penalty program than an incentive program. Hospitals that perform well on quality measures compared to other hospitals and/or improve their performance on the measures will receive value-based incentive payments. Reimbursement will be reduced for those who do not perform well. (For more details on value-based purchasing and a list of quality measures, see p. 166.)

Also beginning in fiscal 2013, CMS will begin penalizing hospitals if they are in the top tier of hospitals with 30-day readmissions for heart failure, pneumonia, and acute myocardial infarction (AMI).

Eventually, hospitals that are in the top 25% of hospitals with 30-day readmissions for the three diagnoses will be penalized as much as 3% of all discharges. Beginning with discharges on or after Oct. 1, 2012, hospitals in the top tier will be penalized by 1% of their total discharges. The figure goes up to 2% in fiscal 2014 and 3% in fiscal 2015.

CMS has announced its intention to add outcomes and efficiency measures to value-based purchasing and to add diagnoses to the readmission reduction program in the future. In addition, CMS has announced a Medicare spending-per-beneficiary performance measure that will be used in the Inpatient Quality Reporting program and for the value-based purchasing program. The spending-per-beneficiary performance measure will be implemented in fiscal 2014 and for the first year, it will be determined by data from hospital discharges cover hospital discharges from May 15, 2012, through Feb. 14, 2013. CMS will calculate the Medicare Part A and B spending per beneficiary beginning three days prior to an admission through 30 days after the patient is discharged from the hospital.

Susan Wallace, MEd, RHIA, CCS, CCDS, director of inpatient compliance for Administrative Consultant Services, a healthcare consulting firm based in Shawnee, OK, explains that during the first year, data from the Medicare spending-per-beneficiary initiative will be used for Inpatient Quality Reporting and posted on the Hospital Compare Web site (http://www.hospitalcompare.hhs.gov). In subsequent years, the data will become part of value-based purchasing, and hospital performance on that measure will make up 20% of the value-based purchasing scores, Wallace adds.

CMS acknowledges that physician management, beneficiary compliance with post-discharge instructions, and availability of community resources might contribute to Medicare spending after discharge, says Deborah Hale, CCS, president of Administrative Consultant Services, Shawnee, OK. "But CMS has stated that hospitals have a significant influence on Medicare spending if they provide appropriate, high-quality care before and during a hospital stay and do a good job of discharge planning, care coordination, and transitioning patients to the next level of care," Hale says. "Medicare spending-per-beneficiary means that hospitals will have a lot more at stake than just finding a place for a patient to go after discharge.

Case managers will need to become involved in decisions about the post-hospital setting and make sure the providers to whom they discharge patients provide cost-effective and high quality care, Hale adds.

Tracking patients after discharge

Beverly Cunningham, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital, and partner and consultant in Case Management Concepts in Dallas, suggests that case management directors start tracking where patients are going after discharge and where patients are coming from when they are readmitted if they aren't already doing so. "It falls back to the case management leadership to know the results of care their patients receive at the next level of care," she says. "If patients who are referred to a certain home care agency or a skilled nursing facility are frequently readmitted, you know there is a problem there."

Taylor says, "Hospitals need to pay close attention to improving quality by making sure they do the right thing in the right way at the right time." For example, reducing infection rates involves using the proper techniques, the right equipment, and the right cleaning methods, but it also means moving patients through the hospital efficiently so the chances of infection are reduced, he says.

However, moving patients through the continuum must be balanced against readmission reduction efforts, Taylor says. "Hospitals have to find a way to provide high-value, cost-effective care while improving care transitions between inpatient and post-acute levels of care," he says.

There is concern in the provider industry that the CMS has not yet found a formula that makes the new reimbursement initiatives fair to hospitals across the board, Taylor adds.

"In the meantime, it's clear that hospitals need to focus on reducing all readmissions and give specific attention to reducing readmissions for patients with heart failure, pneumonia, and AMI," he says. "At the same time, they should pay close attention to the measures CMS designates for value-based purchasing and institute programs to optimize the value they are providing with regard to those measures."

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Value-based purchasing targets performance

Emphasis on quality and patient satisfaction

Beginning in fiscal 2013, Medicare will make incentive payments to hospitals based on how well they perform or how much they improve their performance during a baseline period that began July 1, 2009, and ended March 10, 2010.

In the initial year of value-based purchasing, the Centers for Medicare and Medicaid Services (CMS) will measure hospital performance using two domains: the clinical process of care which includes 12 clinical process measures, and the patient experience of care, using eight measures from the Inpatient Quality Reporting program. In fiscal 2013, the clinical processes of care will be weighted at 70%, and the patient experience of care will be weighted at 30%, when the scores are calculated. (See box on p. 166 for full list of quality measures).

Hospital scores will be based on achievement, or how much their current performance on the measures differs from that of all other hospitals during the baseline period. In addition, hospitals will be assessed based on how much their current performance changes from their own baseline performance period.

Under value-based purchasing, hospitals will automatically receive a percentage reduction on all MS-DRG payments. Depending on their performance on the value-based purchasing measures, they will receive incentive payments, says Susan Wallace, MEd, RHIA, CCS, CCDS, director of inpatient compliance for Administrative Consultant Services, a healthcare consulting firm based in Shawnee, OK. "Some extremely efficient hospitals could earn back more than they lose. Others will be in the bottom percentage of performers and will not be able to earn back the reduction," Wallace says.

Starting in fiscal 2013, 1% of the revenue from all admissions is at stake. It goes up to 1.25% in 2014 and maxes out at 2% in 2017 and beyond.

Under federal law, CMS cannot use a measure for value-based purchasing unless it is part of the Inpatient Quality Reporting program and has been published on the Hospital Compare web site (http://www.hospitalcompare.hhs.gov) for at least a year, says Beverly Cunningham, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital, and partner and consultant in Case Management Concepts, based in Dallas. However, case management leaders need to be aware that anything CMS includes on Hospital Compare can be added to value-based purchasing in the future, Cunningham says.

"CMS is already reporting mortality and readmission data on Hospital Compare and has indicated that it will include average length of stay [LOS] by medical service category as a quality measure sometime in the future," she says. "They've given us our warning, and we need to pay attention." ■

Will you be ready for ICD-10 conversion?

Better documentation will be vital

As the clock ticks down toward the implementation of ICD-10, case managers should start learning about the new coding requirements and how they are going to affect what they do on a daily basis.

The World Health Organization's International Classification of Diseases (ICD) 10th revision (ICD-10) has been used by other countries for many years, says Denise J. Hall, RN, an Atlanta-based partner with Pershing, Yoakley & Associates, a national healthcare consulting firm.

"The United States has been slow to covert because this is the only country where reimbursement is based on the ICD-9 codes. That all changes when every bill for patients discharged on or after Oct. 1, 2013, has to be billed with ICD-10 procedure and diagnosis codes," Hall says.

Otherwise, the claims for medical diagnoses and inpatient procedures might be rejected, and providers will have to resubmit them using the ICD-10 codes.

Hall recommends that hospitals begin training in 2012. While case managers do not need training on the specific codes, they do need to understand the level of documentation specificity required by the new coding process, especially if they're involved in clinical documentation improvement, Hall says. While ICD-9 uses five-digit numeric codes, ICD-10 is a seven-digit alpha-numeric coding system. The expanded fields make it possible to track much more detailed information about the patient's condition.

Quality Measures That Will Be Used for Fiscal 2013

Clinical Process of Care Measures

- Acute Myocardial Infarction
  - — Fibrinolytic therapy received within 30 minutes of hospital arrival
  - — Primary percutaneous coronary intervention within 90 minutes of hospital arrival
- Heart Failure
  - — Discharge instructions
- Pneumonia
  - — Blood cultures performed in ED prior to initial antibiotic received in hospital
  - — Initial antibiotic selection for community-acquired pneumonia in immunocompetent patient
  - — Influenza vaccine
- Healthcare-Associated Infections
  - — Prophylactic antibiotic received within one hour prior to surgical incision
  - — Prophylactic antibiotic selection for surgical patients
  - — Prophylactic antibiotics discontinued within 24 hours after surgery end time
  - — Cardiac surgery patients with controlled 6 a.m. postoperative serum glucose
- Surgical Care Improvement
  - — Surgery patients on a beta blocker prior to arrival that received a beta blocker during the perioperative period
  - — Surgery patients with recommended venous thromboembolism prophylaxis ordered
  - — Surgery patients who received appropriate venous thromboembolism prophylaxis within
  - — 24 hours prior to surgery to 24 hours after surgery
- Patient Experience of Care Measures
  - — Communication with nurses
  - — Communication with doctors
  - — Responsiveness of hospital staff
  - — Pain management
  - — Communication about medicines
  - — Cleanliness and quietness of hospital environment
  - — Discharge information
  - — Overall rating of hospital

Source: Centers for Medicare and Medicaid Services, Washington, DC.

Because the coding for ICD-10 reflects a greater level of detail, coders will need more accurate and detailed information to assign the correct code to the procedure, says Michael Taylor, MD, vice president of operations at Executive Health Resources, a Newton Square, PA, healthcare consulting firm. (For more information on system upgrading for ICD-10, see story on p. 174) This change means that clinicians will have to provide more comprehensive documentation.

"Case managers need to be educated on the level of detail so they can educate physicians on the type of documentation necessary for the coders to do their job," Taylor adds.

When ICD-10 goes into effect, coders are going from a situation in which there are a limited number of codes to choose from, to one in which there are a tremendous number of options, Hall points out. ICD-9 has 14,000 codes for diagnoses and 3,800 procedure codes, compared to 68,000 codes for diagnoses possibilities and almost 73,000 procedure codes in ICD-10. For example, in ICD-9, there are 10 codes for diabetes. ICD-10 has 318 codes for diabetes.

"Every digit in the ICD-10 code means something, and they're all related to something else," Hall says. For example, today, codes for a fracture of a femur specify whether it's an open or closed fracture. "In ICD-10, that explodes into a laundry list of items like

continued on p. 171

EXECUTIVE SUMMARY

In less than two years, the United States will convert to ICD-10, which will result in major changes in coding requirements. Much more detailed documentation will be needed for the coders to do their job correctly.

- Every department in the hospital that uses data will be affected.
- Case management software must be adjusted to accommodate the expanded fields.
- Case managers don't need extensive training on the new codes, but they do need to be aware of the documentation requirements.

CASE MANAGEMENT INSIDER
Case manager to case manager

Handling the transition from staff nurse to case manager

By Toni Cesta, PhD, RN, FAAN
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In October's edition of Case Management Insider, we discussed the importance of using good recruitment and retention strategies in the case management department. Because recruitment is an essential component of retention, this month we will focus on the next generation in case managers: the staff nurses!

Staff nurses are a logical "next generation" for case management. They bring many of the skill sets that contemporary case managers need in order to be effective in their roles. The newest case management models incorporate many roles and functions that are dependent on a strong clinical foundation. Patient flow, coordination and facilitation of care, transitional planning, and resource and utilization management all depend on a strong clinical base from which to draw knowledge to use in working as a case manager in the acute care setting. In fact, when recruiting staff nurses, consider making a match between their clinical areas of expertise and the unit where they will work as case managers. Matches such as this one can make a big difference in their success as they transition into their new role.

> ***Case managers must be skilled at negotiating with patients, families, physicians, insurance companies, outside agencies and vendors, as well as other hospital departments.***

Staff nurses bring additional skill sets to the role of case manager. In addition to their clinical base, they bring a familiarity and knowledge of the acute care setting. They know their way around multiple hospital departments and systems that make up today's acute care environment.

They also understand the process of clinical coordination and facilitation of care. They understand coordination of care from the perspective of the daily care interventions that a patient needs and the efforts necessary to ensure that things happen in an organized and clinically appropriate progression.

For many staff nurses, they are moving from an hourly position to a salaried position. This shift might mean more flexibility in their schedule and the ability to use their time to more greatly meet the needs of their patients.

With the change to case manager, there also might be some concerns for the staff nurse. Being salaried means that they are no longer eligible for overtime, weekend, or holiday differentials or other sources of additional income. So being salaried can be a negative as well as a positive. In addition, while staff nurses are adept at planning for the patient's day, they might be less skilled at planning for the patient's entire hospital stay and beyond. Because many staff nurses work 12-hour shifts, they might never have

developed the skill sets necessary to coordinate care beyond a one-day focus. The acute care case manager must think about today, tomorrow, the day of discharge, and the services the patient will need in the community.

Case managers must be skilled at negotiating with patients, families, physicians, insurance companies, outside agencies and vendors, as well as other hospital departments. This skill set might not be one that they have developed and might raise some concerns from those less comfortable in the art of negotiation. However, learning these skills can be done!

It is highly unlikely that the average staff nurse, coming directly from the bedside, has knowledge in utilization management, discharge planning, transitional planning, Medicare and Medicaid regulations, or other similar elements necessary to be successful in the role of case manager.

Evolving to the case manager position

New case managers must learn to change their focus from a strictly clinical one, to one that incorporates clinical issues balanced with financial and regulatory issues.

The case manager must constantly find a balance between the patients' clinical needs, their healthcare insurance coverage, and other financial concerns. This broader healthcare world view takes time to understand and incorporate into daily practice. The complex role of the case manager requires an ability to be extremely flexible as each day's focus is variable.

Time management and organizational skills must be viewed from a different perspective. As a staff nurse, the day's routine is dictated by medication administration, physical assessments, rounding, and so on. These activities are structured and dictated by specific time intervals.

The day in a life of a case manager is significantly different. One day might be focused on negotiating with a third party payer; another day might be consumed with a complex discharge plan. Some days might involve lots of discharges, while other days could be many admissions. Case managers must quickly learn to adjust as needed and to remain flexible at all times. Time management is a skill that is intensely needed, and some staff nurses might find this aspect of the job overwhelming at first.

Case managers, unlike staff nurses, must extend their communication skills far beyond the walls of the hospital. They must learn to communicate with third party payers, continuing care providers including nursing homes, home care agencies, durable medical equipment companies, city and state agencies, and multiple other options and services. Good communication skills, in addition to an ability to switch from one task to another quickly, are essential to the role. Collaborating with healthcare providers across the continuum takes time to understand and master. It is not learned in nursing school, and it might take time for some to master.

Collaboration must take place inside the hospital as well. Case managers must collaborate and communicate with virtually every department and discipline. The emergency department, medical records, radiology, housekeeping, patient transport, laboratory, and finance are just some of the departments with which case managers have to work. In addition, they have to collaborate with other disciplines including physicians, staff nurses, social workers, physical therapists, respiratory therapists, and others.

As a case manager, you must be familiar with different sets of standards from The Joint Commission, such as patient flow, hand-off communication, and discharge planning. Centers for Medicare and Medicaid Services Conditions of Participation for Medicaid and Medicare also must be understood. Case managers need to understand healthcare reimbursement, how managed care contracts work, and the list goes on.

Data entry and interpretation is another skill set needed by the case manager in today's hospital. Basic computer skills are a must. For example, many case managers are asked to identify avoidable delays and enter them into their case management software program.

At least 50% of hospitals today have some type of electronic repository for case management data and information. This data is easily accessible, retrievable, and reportable. Therefore case managers must have a working knowledge of how to enter data and navigate through these programs. ■

The 9 phases of CM transition

By Toni Cesta, PhD, RN, FAAN
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As case management leaders, you will be looking for the next generation of case managers to come from the bedside. The following information will review the process you might consider using to facilitate recruitment of staff to your department.

• Phase One: Considering transition from staff nurse to case manager.

During this phase, the staff nurse might be thinking about making a career move. They might see the case manager role as a promotional opportunity for them. During this "consideration" phase, you should explore the methods by which you market your vacant case management positions. One strategy might be to have your current case managers "talk up" the department and the positions. When staff members hear from their peers about the pros and cons of the position, it will go a long way in informing their decision-making process. Be sure your staff understands the pros and cons that a staff nurse might be considering. Review these with them so that they can provide objective and consistent information.

• Phase Two: Spending time with a case manager.

The staff nurses who are considering a position in case management might want to spend some time with case managers, so they can see how the role works. Once members of the case management staff have spoken to the staff nurse interested in a position, they also might want to provide them with the opportunity to "shadow" a case manager. See if the more seasoned case managers will provide this opportunity. The staff nurse might want to shadow a case manager for all or part of a day. Ensure that the staff nurses are provided with a positive experience that will reinforce their interest in a case management position.

• Phase Three: The interview.

Job interviews provide a dual purpose. They provide an opportunity for the employer to evaluate the candidate, but they also provide an opportunity for the candidate to evaluate the position. The applicant should be provided with the goals of the position as well as the goals of the department. The interviewer should explain in detail the elements of the position for which the candidate will be accountable. A standard list of interview questions should be developed so that the interviews are consistent across applicants. In addition, other members of the case management team should be given the opportunity to interview the candidate.

Be careful not to overwhelm the candidate. Group interviews can be particularly intimidating, especially to a staff nurse moving from a bedside position. Consider carefully before you plan any group interviews. You might not see the best side of the applicant.

During the interview, review the basic roles and functions of the position, and highlight the strengths that a staff nurse brings to the position. Be sure to also explain that it might be a difficult transition and that the position might take months to master. Reinforce the fact that the orientation will be geared toward their progression in learning their new roles and functions.

• Phase Four: Decision to accept the position.

As the staff nurse makes the decision to cross the bridge to the next level of her nursing career, they will have some confidence that the right decision was made. The opportunity will be present to shadow a case manager, to ask the right questions, and to weigh the pros and cons. We hope he or she will have dealt with any concerns about becoming a case manager.

• Phase Five: Accepting the position.

Once the position has been officially accepted, it is time for celebration. Consider scheduling a lunch or breakfast for the new staff member. Have the incumbent staff share welcome notes with the new employee. Take time to remind the new case manager that accepting the position means that she will be experiencing a significant professional focus change and that they will be moving from a position of experience to a position of novice. For a bedside nurse who has been a staff nurse for several years, this can represent a period of significant insecurity.

Take time to review the job description with the new case manager once again. It might have much more meaning now that it is a reality.

• Phase Six: The initial 30 days.

During the first 30 days in the position, several specific areas should be the focus. This time should be one of the new case managers becoming acclimated. Have an expert case manager or case management leader review policies and procedures as well as any specific rules and regulations that the new employee might need to become familiar with.

A useful strategy is to solicit the help from employees in other areas in the hospital to assist with orientation. Examples of these might be finance, quality management, patient relations, medical records, emergency department, admitting office, laboratory, and radiology. Exposure to these areas can be quite helpful to the new case managers and add significantly to their knowledge base.

Other points of discussion should include information systems such as the case management software, bed control software and discharge planning software.

Allow the case manager to shadow a social worker so that they will have first-hand experience in the roles and functions of social work. They will be referring patients to the social worker and will need to have a very clear understanding of the differences in roles and functions between the nurse case manager and the social worker.

Provide the case manager with an organizational chart of the case management department. Remember that this might be their first organizational chart and you might need to explain it.

Finally, meet every Friday afternoon to discuss and review goals achieved for the week and areas that might need additional focus. Taking the time out to do this will pay off in the end as you will have a better prepared and more effective employee.

• Phase Seven: First 90 days.

During the first 90 days in the life of a new case manager, communication skills should be developing. Learning how to communicate while juggling a variety of tasks can be daunting at first, but it should get better with time. The new case manager must change their relationship with the patient from one shift to the entire acute care episode. This change in orientation to the patient and family is critical. During this time, the case managers are learning how to communicate ever-changing information to the rest of the interdisciplinary care team, but they also are learning how to receive information. This information might have to be sought out and might require extra effort on their part.

The interdisciplinary care team now moves beyond the walls of the nursing unit to include ancillary departments as well as care providers in the community. Community interfacing will include clinicians as well as non-clinical professionals such as payers, regulatory bodies, and intake clerical staff. It will be important that the case manager build relationships with patients, families, players, care providers, and physicians, and that they mature in their new role.

• Phase Eight: First six months.

Toward the end of the first six months, the case management leader should be assessing the level at which the new case manager is functioning. At this point, the case manager should be able to set goals with the patients, as well as the families. They should be able to understand reimbursement systems as well the hospital's payer mix. They should be able to articulate the hospital and the case management department's goals and status toward meeting those goals. They should be able to explain how their role impacts the achievement of the goals and the specifics.

The case management leader should be reinforcing the new case manager's growth and achievements. Specifics as to their impact can go a long way in helping them feel confident in their new role and have a sense of job satisfaction. The leader should be encouraging them to move toward a higher level of autonomy and flexibility in their role.

• Phase Nine: First year.

By the end of the new case managers' first year, they should be well established in the department's culture. They should identify and see themselves as case managers and no longer as staff nurses. At this point, the case management leader should feel comfortable in assigning them more challenging work. Examples might include training a new orientee or joining a committee or task force.

Following a structured process and working through it with your new case managers will help you to retain them by increasing their job satisfaction and ensuring that they feel that they are a valued member of your department and your organization. ■

continued from p. 166

right or left leg, delayed healing, subsequent versus initial encounters," Hall says. "It's all very specific, and the documentation has to be complete so the coders can assign the right code."

The silver lining to ICD-10 implementation is that the detailed documentation required for coding is likely to help hospitals avoid denials from the recovery audit contractors (RACs) and other auditors, Taylor says. "The type of documentation needed for ICD-10 fits very well into the type of documentation we've seen work best to defend medical necessity," he says. "The level of detail in documentation needed to enable billers and coders to do their job appropriately using ICD-10 is the same level of detail that hospitals need to defend the claim if medical necessity is questioned."

Hall adds, "The shift to ICD-10 represents a lot of opportunities for hospitals right now if they begin to work on shoring up their documentation. If hospitals begin to work on improving documentation and making it as specific as possible, they may be able to see results almost immediately in the reduction of denials."

Every department involved

Hospitals need to be aware that ICD-10 touches almost every department: not just coding, information technology, and case management, but also patient access, revenue cycle management, social work, and ancillary services, Hall says. She advises case management directors to start to determine what ICD-10 will mean to their department and what changes they must make to make the transition to ICD-10.

Current hospital information technology is designed to store a five-digit field for coding, while ICD-10 uses a seven-digit field, says Joanna Malcolm, RN, CCM, BSN, consulting manager, clinical advisory services for Pershing, Yoakley & Associates in Atlanta. "ICD-9 codes are used in all the reports that case management directors use every day, such as quality indicators and core measures compliance," Malcolm says. "Case management software has to be updated to accept the expanded fields and to interface with all of the other information technology that uses ICD-10 codes."

In addition, keep in mind that insurance companies are going to need ICD-10 information to approve hospital stays and services, as well as post-acute services, she adds.

Hall suggests assessing and mapping the data flow process that now uses ICD-9 to establish where ICD-9 coded data is stored, captured, and transmitted throughout the patient stay. Determine what you will need to make the transition, including technology, staffing, and training.

Taylor adds that physician documentation is going to be a key factor in a successful ICD-10 conversion. It's not too early to start educating the physicians on the general principals of ICD-10, he says. "They need to know that their documentation needs to be more specific because the codes are more specific," Taylor says.

SOURCE

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Successful initiative cuts readmissions

Follow-up calls are a key component

After Bassett Medical Center in Cooperstown, NY, began a multidisciplinary program to reduce readmissions, the 30-day readmission rate for high-risk patient diagnoses dropped 70% from 13.4% in 2009 to 0.7% 2010. The initiative earned the medical center a Pinnacle Award for Quality and Patient Safety from the Hospital Association of New York State.

"We recognized that we had the opportunity to improve our overall readmission rates, not just for high-risk patients," says Lorraine Stubley, RN, MS, senior director of care coordination. "We knew that we weren't doing that badly, but there was still room for improvement."

The initiative includes assessing all patients for risk of readmission, creating easy-to-understand discharge instructions, making follow-up calls to at-risk patients, overcoming barriers to follow-up care, developing alliances with post-acute providers, and enhancing communication with primary care providers and specialists.

A key component of the readmission reduction project is the Society of Hospital Medicine's Project BOOST (Better Outcomes for Older Adults through Safe Transitions). Stubley and Komron Ostovar, MD, FHM, a Bassett hospitalist, were appointed to lead the multidisciplinary effort to develop a comprehensive care transitions approach to reduce readmissions. The hospital is an official Project BOOST site and works with a mentor who provides telephone consultation, teleconferences, and site visits, Ostovar says.

Although Project BOOST is designed for use with

EXECUTIVE SUMMARY:

Bassett Medical Center's multidisciplinary readmission reduction program resulted in a 70% drop in readmissions for high-risk diagnoses at the Cooperstown, NY, facility.

- Case managers assess all patients for risk of readmission and alert the team when patients are at high risk.
- Staff members use the teach-back method and have simplified discharge instructions.
- Case managers and nurses try to identify barriers to follow-up care while the patient is in the hospital.
- A patient services coordinator calls at-risk patients after discharge.

older adults, the Bassett team decided to expand the program and use it for all patients. Stubley says: "We found that age is only one factor that can put patients at risk for readmission. In our area, we have some very healthy older people and some young people with a lot of health problems."

Early on in the inpatient stay, case managers assess patients for their risk of being readmitted. Some of the factors they consider are principal diagnoses, medication changes, polypharmacy, psycho-social issues, health literacy, prior hospitalizations, and need for palliative care. When the assessment indicates that patients might be at risk for readmission, the case manager adds the letter "Q" to the electronic medical record, which alerts the treatment team.

Heart failure and diabetes were among the most frequent diagnoses of readmitted patients, Ostovar says. Oncology patients who have uncontrolled pain also were frequent readmissions, along with other patients who have palliative care needs that in the past were not identified early and treated aggressively, he says.

Stubley and a pulmonologist conducted a study on readmitted pneumonia patients and determined that many of the patients had end stage chronic obstructive pulmonary disease. They needed palliative care or hospice care but had not been receiving it. "We hadn't been having the difficult conversations with patients to discuss palliative care and hospice. This was one of our biggest opportunities to reduce pneumonia readmissions," she says.

The team examined evidence-based behavior and following the Project BOOST guidelines, developed a comprehensive care transitions approach. Ostovar says: "We worked for more than a year designing the program, [then] implemented the program on a medical unit."

The hospital hired a patient services coordinator who calls at-risk patients within 72 hours after discharge. The coordinator checks on their progress and answers any questions. The coordinator also makes sure they have filled their prescriptions and have a follow-up appointment with their primary care physician or a specialist. The patient service coordinator calls about 100 high-risk patients a month who are at risk for readmissions and follows up with patients who have heart failure, pneumonia, diabetes, or cardiac surgery. The ultimate goal is to call every patient discharged from the hospital within 72 hours.

In addition, patients being discharged receive an "800" number they can call any time between discharge and their first follow-up appointment if they have any questions or concerns. Stubley adds: "The number connects them to a case manager or social worker. It's been a tremendous opportunity for us to take care of any problems while they are still small."

Under Ostovar's leadership, the hospital revised its discharge instruction forms to make them easy to understand. "We know that you can have the best possible plan in mind, but if the patient goes home and goes back to taking the medicine he took before being hospitalized or doesn't understand when to call the doctor, he's likely to be readmitted," he says.

The revised discharge instruction forms use layman's terms instead of medical terms. For example, the hospital changed the term "principal diagnosis" to "why I was in the hospital" to make it more understandable. When the team asked for comments on the new discharge instructions at a community forum for further input, participants asked, "What is a PCP?" This question prompted the team to spell it out on the form.

The hospital changed its case management model to assign case managers by unit, which improved communication with the bedside nurses. "We have been working to take down the barriers one by one," Stubley says. For example, transportation is a significant issue with some patients. Hospital leaders set up an account with a cab company. Staff members give patients a voucher, which guarantees payment for transporting patients to their physician visits.

When case managers, nurses, and physicians provide education for patients and family members, they use the "teach-back" method to ensure that they understand.

The case management department has worked closely with area nursing homes and home health agencies on how to improve transitions in care. In addition, the patient services coordinator has developed key relationships with the largest volume clinics and specialist offices who serve Bassett patients. "When they know one of our patients is at high risk

for readmission, they accommodate them with a timely appointment," Stubley says.

SOURCE/RESOURCE

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For information on Project BOOST, visit www.hospitalmedicine.org/BOOST. ■

Literacy screen of parents helps cut costs

Alerts when parents need extra education

A pilot program in which parents or caregivers of patients were screened for health literacy reduced healthcare costs and emergency department use for patients at Cook Children's Medical Center in Fort Worth, TX.

Parents and caregivers who did not successfully screen received additional comprehensive education on caring for the children during the pilot program initiated in March, 2008. The program generated an average savings of $3,545 per patient when costs were measured against those incurred by select group of members in the Cook Children's Health Plan, according to Margie Dorman-O'Donnell, RN, MSN, director of case management.

"We believed that poor literacy among the parents played a role in lack of compliance to the treatment plan following discharge, but we didn't know how to address the problem," O'Donnell says. "Our answer came when Cook Children's created a new 10-bed unit for children who need short stay observation or extended treatment, such as for asthma."

Working with their three physician advisors, the case management team researched ways to screen for healthcare literacy and selected the Newest Vital Signs screening tool to determine the literacy of the parents. (For information on the tool, see Resource, p. 174.) Parents of every child admitted to the short-stay unit are assessed for healthcare literacy.

"Good literacy skills are paramount if we expect parents to understand the discharge plan," Dorman-O'Donnell says. "Parents need to follow at home what they learned in the hospital. For instance, they need to be able to read and understand prescription labels and to know that their children need to take their medicine at a certain time and how many pills or milliliters of liquid they need to take."

Parent and caregiver education at Cook Children's incorporates the teach-back method, which asks the parents to repeat what they have been told and the "Ask Me 3" tool to further determine parents' understanding of their child's hospital stay and discharge instructions. "Ask Me 3" questions are: "Do you know why your child is in the hospital?" "What do you need to do when you get home?" and "Why do you need to do that?"

Everyone on the unit, including the nurses, the interpreters, the pharmacist, the respiratory therapist, and the RN case manager is trained on "Ask Me 3" and teach back. The two tools are used to assess each family's level of understanding, but the amount of time they spend teaching each family varies significantly. Those who did not successfully screen for healthcare literacy are enrolled in a special case management program that includes more focused teaching and post-discharge follow-up to assess their understanding and compliance with discharge instructions. The education is repeated frequently throughout the stay and again at the time of discharge.

"We want to make sure that the parent understands the child's condition and how to take care of it," Dorman-O'Donnell adds.

The unit's RN case manager calls the parents who did not successfully complete the literacy screen 5-7 days after discharge to determine if they are following the discharge instructions. During the call, the case manager reinforces hospital teaching, checks on follow-up appointments with primary care physicians, and arranges transportation if the family needs it.

"Initially, we called them back one or two days after discharge but we determined that it was too early to get an accurate assessment of compliance with the medication regimen," Dorman-O'Donnell says. "A lot of parents stopped giving the children their medication after they started feeling better. Since most prescriptions are for a seven-day supply, by waiting, we can determine if they have taken all or almost all of the medication."

Simplifying teaching materials is an ongoing process, she says. "Medication administration is one area of improvement in Cook Children's discharge teaching process," Dorman-O'Donnell adds.

Working with the hospital pharmacists, the short-stay unit team developed a color-coded tutorial to instruct parents on how to give their children their medication. The instructions have a colored dot for each medication that corresponds with the color on the prescription label. Instead of using "morning," "noon," or "evening" to designate when the medication should be taken, the hospital uses a rising sun for early day, a full sun for mid-day, and a moon for eve-

ning. When patients fill their medication somewhere other than the hospital pharmacy, the case manager calls the pharmacy and asks that the label be color-coded as well. In special cases, such as when parents are color blind, the pharmacist pastes one pill on the bottle and another on the instruction sheet.

When members of the unit team use "teach back" and "Ask Me 3," they are not evaluating how much information the parents know. They are evaluating how well they are teaching the information, Dorman-O'Donnell says. "Parents want to do what is right and what is best for their child," she says. "Some of the parents learn by seeing, some by hearing, and some by doing. Our challenge is to figure out the best method for delivering information to our parents at their level of understanding."

RESOURCE

The Newest Vital Signs tool, available in English and Spanish, is based on a nutritional label from an ice cream container. The parents (or in the case of adults, the patients) are given the label and asked six questions about the label. Their answers enable the healthcare professional to determine their ability to read, understand, and act on healthcare information. For more information, see: http://www.pfizerhealthliteracy.com, click on "Physicians & Other Providers," then click on "Risk Assessments & Screening," and "Newest Vital Sign." ■

ACCESS MANAGEMENT
QUARTERLY

Access technology will need revamping

Now is the time to get involved

Systems will need to be remediated if they will be used to check medical necessity for ICD-10 standards when they are implemented in October 2013, says Jeffrey Smith, RN, MBA, CPC, a New York City-based manager at Accenture Insight Driven Health, a management and technology consulting company.

Patient accounting and registration systems will need to be upgraded to accept the increased field length of diagnosis codes, he explains.

Third party web-based systems for obtaining pre-authorizations and certifications will need to be updated to meet ICD-10 standards, along with ancillary systems used by lab and radiology, adds Smith.

Smith gives these recommendations to prepare:

• Inventory all third party systems used in the scheduling/registration and authorization process.

"Sometimes systems aren't all fully integrated," notes Smith. "It is a question of where you are doing registration and scheduling. Some systems might fall outside patient access, like lab or radiology."

Even if staff members are not capturing the diagnosis code, says Smith, the systems still might need to be remediated if they are working in areas where scheduling is done. "If they are doing any checking for medical necessity, that clearly needs to be identified," he says.

• Determine timetables for upgrading systems.

"If you have a third party system that is utilizing diagnosis code information that is being captured at the time of registration, you need to know when that vendor is going to have that system ready for ICD-10," says Smith.

While this task probably will be handled by members of the IT staff, they might not be aware of all the systems patient access is using to process diagnosis code information, Smith adds.

• Examine all patient access workflows to determine whether ICD-9-CM diagnosis codes are utilized and processed.

"You will probably need to flow out in detail all the workflows that involve the handling of the diagnosis codes," Smith says.

Identify when data is coming in from third parties, such as any paper requisitions from community physicians, says Smith. "If you are processing any diagnosis codes from these, there would potentially be an issue with ICD-10," he says. "If you are receiving an inaccurate and incomplete diagnosis and you are trying to determine medical necessity, follow up with those particular provider offices."

Consider web-based applications used in your department, because payers might have certain systems where diagnosis codes are entered, says Smith.

Systems upgraded

Vanderbilt University Hospital in Nashville, TN, is creating a web-based tool for staff to use as a quick reference, with a list of the top 50 conditions and 25 procedures.

"It also has a listing of payers which will require ICD-10 codes," says Marsha Kedigh, RN, MSM, director of admitting, ED registration, discharge station, and insurance management.

The department is upgrading its registration system to expand the fields to accept the longer code and increased volume of codes and upgrading internal

insurance web sites used by staff to assist with coding, says Kedigh.

The emergency department's electronic whiteboard houses the ICD-9 codes and also will need upgrading, adds Kedigh, as the ED physician attaches the appropriate code to the patient via the whiteboard based on diagnosis.

At Mission Hospitals in Asheville, NC, staff will use an encoder to provide the ICD-10 codes, based on the verbiage provided by physicians. Susan Hoyle, CCS, coding manager, says, "Patient access will utilize a medical necessity checker to verify that codes meet criteria for coverage for Medicare." ■

CNE QUESTIONS

1. True or False: Under new reimbursement initiatives from the Centers for Medicare and Medicaid Services, hospitals will have to outperform other hospitals in order to avoid cuts in reimbursement.
   A. True
   B. False

2. Under value-based purchasing, what percentage of weight is given to the 12 clinical processes of care measures?
   A. 20%
   B. 30%
   C. 50%
   D. 70%

3. When is ICD-10 required for billing in the United States?
   A. With discharges beginning Oct. 1, 2012
   B. With discharges beginning July 1, 2013
   C. With discharges beginning Oct. 1, 2013
   D. With discharges beginning July 1, 2014

4. When Lorraine Stubley, RN, MS, senior director of care coordination, and a pulmonologist at Bassett Medical Center, conducted a study of readmitted pneumonia patients, what was the major opportunity to reduce readmissions that they identified?
   A. Counseling end-stage chronic obstructive pulmonary disease patients about palliative care and hospice options.
   B. Making sure patients have follow-up appointments with a primary care physician and/or a pulmonologist.
   C. Conducting thorough medication reconciliation while the patient is in the hospital.
   D. Follow up phone calls to ensure that patients are following their treatment plan.

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Nurses participate in this continuing education program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
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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's the best case management model for your facility?

■ What's ahead in Medicare regulations

■ How your peers are reducing readmissions

■ Tips for avoiding RAC recoupments

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