HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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Observation or inpatient? Get it right up front

Auditors are carefully scrutinizing your records

As the Centers for Medicare and Medicaid Services ramps up its Recovery Audit Contractor (RAC) program, and other auditors begin scrutinizing hospitals records, it's imperative that hospitals make sure that the patients' level of care is appropriate and that the medical record has adequate documentation to support it. *(For more information about the importance of level of care, see story, p. 3)*

Hospitals are reporting significant increases in medical records requests and RAC denials. As records requests increased, so do the denials. "There are a myriad of auditors trying to second-guess whether patients should be inpatients or kept as outpatients with observation services. Hospitals' feet are being held to the fire more," says **Deborah Hale**, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, a healthcare consulting firm based in Shawnee, OK. *(For more information about patient status, see story, p. 5)*

Brian Pisarsky, RN, MHA, ACM, manager in Huron Healthcare's Clinical Operations Solutions, with headquarters in Chicago, adds that getting patient status right upfront is often a challenge. There are a lot of grey areas in the rules and admission criteria sets don't always apply to every patient.

He reports that there are instances where patients meet medical necessity criteria for inpatient stays but the RACs are denying the stay. "CMS has not given a consistent message regarding whether InterQual and Milliman criteria should be used as a decision-maker on medical necessity. While hospitals have concrete processes for deciding if patients meet admission criteria, the RACs are saying that medical necessity criteria sets are merely tools," he adds.

It's not possible for hospitals to have a physician advisor review every admission, Pisarsky points out. "Admissions should be based on medical necessity criteria, with additional supporting documentation from the physician when that information is required to clearly show the reason for inpa-

tient status. Case management staff can play a critical role in ensuring the level of care documentation is accurate and sufficient," Pisarsky says.

Teresa Fugate, RN, BBA, CCM, CPHQ, vice president, case management services for a seven-hospital system with headquarters in Knoxville, TN, adds that physicians make the decision to admit patients as inpatients or keep them as outpatients with observation services based on the information they have in hand, Fugate points out. For instance, a patient presents to the emergency department in severe pain with a renal stone and the physician prescribes IV antibiotics. The patient meets inpatient criteria but if he passes the stone at 6 a.m. and was discharged, it may appear that it wasn't an appropriate inpatient admission.

"The RAC is likely to pull the case for review and could deny it if the documentation doesn't show that the physician believed at the time of admission that the patient would be in the hospital for a longer period of time," she adds.

Hale says that many hospitals have not done a good job of submitting adequate information for the RACs and other auditors to make a valid decision on medical necessity.

"The problem is not whether or not the patient needed the particular service. It's whether or not the hospital will be reimbursed from Medicare Part A for inpatient services or Medicare Part B for outpatient services," Hale continues.

Insufficient physician documentation makes up a big portion of inpatient hospital payment errors, Hale says. In some cases the physician progress notes, physician orders, diagnostic tests, and examination and treatment records are incomplete or missing, or, in some cases, the documentation was

EXECUTIVE SUMMARY

Auditors from all types of payers are focusing their attention on patients' level of care making it imperative for hospitals to ensure that the level of care is appropriate and the documentation supports it.

- There are a lot of grey areas in the rules and admission criteria sets and the Recovery Audit Contractors (RACs) are looking at them as tools, and not as definitive answers as to whether patients meet inpatient criteria.
- Insufficient physician documentation is the reason for a large number of hospital payment errors.
- Level of care determination doesn't necessarily affect physician billing but it can have a huge impact on hospital reimbursement and patients' out-of-pocket expenses.
- Patients appropriate for observation services are those who need additional care or who need to be reassessed before a decision on admission is made.
- At some hospitals, case managers on the surgical unit conduct reviews to ensure that patients are placed in the proper status after surgery.

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illegible. Case managers should work with physicians to ensure that the documentation is clear and complete and that the level of care is appropriate, she says.

"Physicians should accept advice from a case manager on whether a patient meets inpatient criteria but it's a complex medical judgment that can be made only after the physician has considered what he or she knows about the patient's medical history and how the severity of the signs and symptoms the patient is exhibiting affect the treatment plan and influence the length of stay," Hale adds.

Make sure that your hospital records clearly reflect what level of care the physician intends for the patient. Hospitals and physicians use multiple terms to indicate that the intent is an inpatient admission, but to CMS "admit" means an inpatient admission. Observation is not a status — it's a service, she points out.

Pisarsky suggests having case managers at all points of entry to review all emergency department admissions, direct admissions, and surgical admissions and to make sure that the patient status is appropriate up front, rather than trying to correct it after admissions.

If there isn't enough staff to review cases at the time of admission, hospitals need policies and a clear and consistent utilization review plan describing how and when the review is going to take place, he adds. The documents should include details on how initial reviews and continued stay reviews are performed, how cases are referred to the physician advisor, and how the hospital provides day-to-day reviews as part of the Medicare Conditions of Participation, he adds.

Hospitals should have a written policy stating that patients do not receive a bed until there is an appropriate status order on the chart, Pisarsky says. Train the staff that assigns beds that they can't give a patient a bed until the order is appropriate, he suggests

"If hospitals don't have consistent processes in place for review and documentation, they are leaving themselves open for additional RAC reviews. Auditors are not going away. In fact, more and more auditors are scrutinizing hospital records. Hospitals have to get the status right up front or face continued denials," he says.

Hale recommends that hospitals make sure their case management policies and procedures are consisted with the CMS requirements. Educate the medical staff on admission criteria and conduct inter-rater testing for case managers to make sure they are applying admission criteria consistently, she adds. ■

Why level of care is so important

Inappropriate status hurts hospital, patients

The Medicare Recovery Contractors (RACs) are zeroing in on admission status and denying cases because they say the patient was appropriate for outpatient observation services, rather than an inpatient admission.

Many times, a patient's level of care doesn't impact physicians' billing or how the patients receive care but it has a dramatic impact on hospital reimbursement as well as the patient's out-of-pocket expenses and/or eligibility for skilled nursing care, says **Brian Pisarsky**, RN, MHA, ACM, manager in Huron Healthcare's Clinical Operations Solutions, with headquarters in Chicago.

Deborah Hale, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, a healthcare consulting firm based in Shawnee, OK, reports that most of the time the best case scenario for observation is a payment of around $1,000. She points out that for many diagnoses, such as heart failure, the payment is higher on the inpatient side if a patient has a complication/comorbidity but the payment for observation is the same regardless of a secondary diagnosis.

For instance, outpatient observation payment for a patient with congestive heart failure whether with or without a complication/comorbidity is typically less than $1,000. Hospitals would receive $5,666 for inpatients with a complication/comorbidity and $3,769 for patients without a complication/comorbidity. Both figures are based on a hospital-specific DRG rate of $5,500.

Pisarsky points out that since Medicare Part B has a 20% co-pay for patients, those who receive observation services incur out-of-pocket expenses unless their Medicare supplemental insurance covers outpatient co-pays but an inpatient stay would be paid for by Medicare Part A. In addition, when patients receive observation services but, after review, the hospital converts their status to an inpatient admission, their length of stay may not be long enough for them to meet Medicare's three-day requirement to qualify them for a skilled nursing stay, he adds.

"If there is a delay in writing an order for an inpatient admission that is clearly justified, the patient may not qualify for a skilled nursing stay," he says.

For instance, if a Medicare patient meets inpatient criteria on Day 1 and the date and time of the

inpatient admission are on the chart, the patient is qualified to have Medicare pay for a skilled nursing stay if he is hospitalized overnight for three days. If the same patient arrives at night and is put in observation, then it is determined the next day he meets inpatient status, technically he had only two nights as an inpatient and a skilled nursing stay will not be covered by Medicare. ■

Is observation always appropriate?

Only when patients need more care

As the complexity of outpatient procedures continues to increase, more patients are staying for 24 hours but this does not make them observation patients, says **Deborah Hale**, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, a healthcare consulting firm based in Shawnee, OK.

Observation services are commonly ordered for patients who present to the emergency department and require a significant period of treatment or monitoring in order for the physician to make a decision to admit or discharge them. "Observation is required for those who have complications and need additional care, not for those who just need more time to recover. Patients who are appropriate for observation may be exhibiting minor signs and symptoms and the physician wants to reassess them before a decision to admit or send them home is made," Hale says.

A 24-hour stay in observation has been the benchmark, Hale says. She advises case managers to get the physician to make a determination before the 24 hours are up. "Something is wrong when patients consistently receive observation services for more than 24 hours. The hospital either is not fast-tracking the patients the way it should be or they should have been admitted in the first place," Hale says.

Routine post-operative monitoring or routine preparation for diagnostic testing and the recovery period afterward do not quality as observation. In addition, Observation is not appropriate for medically stable patients who need diagnostic testing or procedures, such as blood transfusions, chemotherapy or dialysis, that routinely are provided in the outpatient setting.

When determining whether a patient should receive observation services, physicians should take into consideration only what directly affects the safety and health of the patient and whether the patient's medical needs are such that he or she can be safely treated only in the hospital setting, Hale says.

"Physicians should never take into consideration family pressure or what the patient wants. Observation services must be reasonable and necessary and not used as a hotel while the family is making nursing home arrangements," Hale says.

According to **Brian Pisarsky**, RN, MHA, ACM, manager in Huron Healthcare's Clinical Operations Solutions, with headquarters in Chicago, as the Medicare Recovery Audit Contractors (RAC) turn their attention to surgical admissions as well as medical admissions, hospitals need someone with expertise to review surgical orders and make sure the patient status is correct at the time of surgery, *(For details on how surgical case managers work at two hospitals, see related articles on pages 6 and 7).*

Hale points out that if hospitals don't have an order to admit prior to the performance of a procedure on Medicare's Inpatient Only Surgery List, the hospital can't be paid but the surgeon is reimbursed.

"The inpatient only list has been a key component of the Outpatient Prospective Payment System since the proposed rules were developed 1998, Hale says. The provider community has continuously asked CMS to get rid of the list or allow for appeals due to special circumstances but CMS has refused to do so.

CMS says that the Inpatient Only list doesn't block the procedure from being performed in the outpatient setting but Medicare will not pay for it if it is.

"Hospitals have the responsibility to educate physicians about the Inpatient Only list and to make sure there is a process in place to ensure that there is an order to admit prior to the performance of the procedure," Hale says.

A patient who is scheduled for outpatient surgery and converted to a procedure on the inpatient only list during the surgery is an outpatient. "CMS has not addressed this scenario in written regulations but stated in a 2007 Open Door Forum that a physician may give an order to admit as an inpatient immediately following the procedure and still bill the claim as an inpatient claim," Hale points out.

An example is a patient who was scheduled for a laparoscopic cholecystectomy and after the surgery begins, the surgeon must change the planned procedure to an open cholecystectomy (a procedure on the inpatient only list). "The surgeon should not wait until discharge to order an inpatient admission," she says.

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Proactive approach predicts patient status

Surgical case manager reviews all procedures

Sherman Hospital in Elgin, IL takes a proactive approach to ensuring that surgical patients are placed in the proper status by asking physicians to fill out a surgical reservation form before the surgery is scheduled.

The form includes space for the name of the surgical procedure, the CPT code and the ICD-9 code for the diagnosis. It has space for insurance and pre-authorization information and boxes where physicians can check to indicate if they predict that the patient will be an outpatient, be admitted as an inpatient, or require an extended recovery.

In addition, the hospital has dedicated a case manager to the surgical unit to review all scheduled surgeries and ensure that they are in compliance with Medicare and other payer guidelines.

"There's too much money at stake not to do this. We want to get the patient status correctly established up front to avoid having the Recovery Audit Contractors (RACs) take back the whole payment for surgeries done in the wrong setting," says **Ronald Hirsch**, MD, FACP, medical director of care management for the 255-bed hospital, and physician advisor in case management for B.E. Smith healthcare consulting firm with headquarters in Lenexa KN.

The surgical reservation form, which is available on the Sherman Health Documents website reminds physicians that observation services must be ordered after surgery and only if there is a medical reason to monitor the patient. It instructs them that Extended Recovery should be chosen for non-medical patient stays that are for the convenience of the physician or patient.

The Sherman Health document library also has a copy of the Medicare Inpatient Only List and instructs surgeons that if a procedure is on the list, they should order an inpatient admission and that if procedures are not on the list and surgeons want to admit the patient, they must document the reasons on the medical record. The website also includes a page describing outpatient, inpatient, and extended recovery and when each is appropriate.

Once the physician fills out the form, he or she faxes it into the scheduling department. The scheduling nurse reviews it to determine if the procedure is on the Medicare Inpatient Only list and, if so, to make sure the doctor has ordered an inpatient admission. If not, the nurse contacts the physician and asks for new orders. When the patient gets to the surgical unit, **Heather LaCoco**, RN, BSN, surgical care case manager reviews the record to make sure the orders are appropriate and the documentation is complete.

"A big part of my job is educating the surgeons and their office staffs about the difference between observation services, inpatient admissions, and extended recovery to help them understand the appropriate admission status for their patients. Surgeons just want to be doctors and surgically fix their patients and safely send them home. Case managers are the glue that puts it all together to make sure patients receive the care they deserve, that insurance and Medicare regulations are followed, and the hospital is capturing the information it needs to be appropriately paid for the care we deliver," LaCoco says.

The post-operative order sheet gives surgeons three choices: they can leave the status they designated pre-operatively, change it to an inpatient admission, or order observation services for the patient. "We've worked hard to educate the physician that observation is indicated only when patients need monitoring beyond the usual recovery," Hirsch adds.

The hospital created the information sheets and forms for physicians after reviewing the RAC rules and records, and determining that in many cases, observation was not appropriate. "We also realized that some surgeries that were on the Medicare Inpatient Only list were being performed as outpatient procedures and that there were instances where older patients with comorbidities needed inpatient care after routine procedures that were not on the list. The orders were not appropriate and we were being poorly compensated for the services we provided," Hirsch says.

The hospital has created an Extended Recovery status for patients who need to stay overnight but their condition doesn't warrant observation services or an inpatient stay. An example is a patient

who has a procedure that Medicare has deemed to be outpatient surgery but the physician isn't comfortable sending the patient home after a four-hour recovery.

"The hospital gets no additional payment for patients in extended recovery but it keeps the surgeons happy and the patients appreciate it," Hirsch says.

LaCoco reports spending a lot of time educating physicians and office staff about the need for accurate documentation and making it simple for them to get the right patient type, so the hospital can capture the services it is providing for patients and get paid appropriately.

For instance, a laparoscopic colectomy might be a simple outpatient for some patients but not for an 82-year-old patient with heart failure, chronic obstructive pulmonary disorder, and diabetes. "In this case, we need to educate the surgeon and the office staff to document that due to his comorbidities and risk factors, the patient needs to be admitted after surgery for close monitoring and medical management. This way we are capturing patient needs and are able to bill accurately for the care we provided," she says.

SOURCES/RESOURCE

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Sherman Health Document Library - www.ShermanDocs.com. ■

Dedicated case managers review surgery schedule

Inpatient vs. outpatient is the focus

At Port Huron Hospital in Port Huron, MI, a full-time case manager is dedicated to the surgery department and reviews the cases of all patients scheduled for surgery to make sure they are in the proper status.

Hospitals must walk a fine line when it comes to determining if surgical patients who need more than normal recovery times should be admitted or remain as outpatients with observation services, says **Rochelle Schiller**, RN, MBA, director of care management at the 186-bed community hospital. Hospitals lose money if they provide observation services for patients who meet admission criteria. On the other hand, if they have a lot of one-day inpatient stays, it attracts the attention of the Medicare Recovery Audit Contractors (RACs), she adds.

"We determined that we needed someone on site to prospectively conduct a clinical review of surgical cases. We knew we needed an RN case manager with expertise in admission criteria to make sure the patients are in the proper status. A case manager dedicated to the surgery department was the solution," she says.

Working with the hospital administration and the business office, Schiller conducted an analysis of surgical cases over the course of 12 months. The analysis showed that in some cases, procedures were ordered as outpatient procedures but the patients were being transferred from recovery to the inpatient unit for a variety of reasons. "Some had clinical issues. Others were social admissions, and some simply didn't belong there," Schiller says. In all cases, the hospital was getting paid only for the outpatient services and not for the inpatient stay, she says

"We were losing revenue on some patients who met medical necessity criteria but were kept overnight as outpatients. We also determined that there were a lot of outpatients in beds when their care was not reimbursable," she says

The case management department worked with the business office to track all of the write-offs because the patients were treated as outpatients but the procedure was on the Medicare Inpatient Only list. "We were missing the boat on some inpatient procedures. The procedures were being booked as outpatient procedures and the patients were being kept in observation so we weren't getting paid," she says.

The case management team looked for trends and picked the 15 most common procedures where there were problems, then educated the surgeons about the Inpatient Only List, starting with those who performed the most common procedures. In addition, the surgical case manager compares the procedures scheduled for Medicare recipients to the Inpatient Only list and makes sure that an inpatient stay is ordered. We want to admit patients if they are having procedures on the Inpatient Only list so we can get paid correctly," she says

The hospital's RAC recently issued 44 requests for records on patients receiving cardiac cath-

eterizations. "Cardiac catheterizations typically booked as an outpatient procedure but when something happens during the procedure, the physician orders the patient to stay over as an inpatient. We're working to ensure that the physicians document the reason for the admission so we can be paid appropriately and have the information in place to withstand a RAC audit," she says.

As part of their initiative to place patients in the correct status, Port Huron Hospital created an outpatient extended stay level for patients who need to stay overnight for non-clinical reasons, such as they don't have a ride home or the doctor doesn't discharge them until the next day.

The extended stay level enables the hospital to put patients in a bed overnight without billing Medicare. "It doesn't generate a room charge so it doesn't count as a one-day stay and there's no red flag for the RACs. We have compassion for patients who can't get home late in the day but it's not appropriate for us to bill for those services," she says.

SOURCE

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Hospitals, providers collaborate on transitions

Goal is to reduce readmissions

In order to facilitate smooth transitions between levels of care and ensure that patients continue to recover after they are discharged from the hospital, Baystate Health, with headquarters in Springfield, MA, is partnering with post-acute providers and meeting regularly to discuss opportunities for improved patient care and partnership.

Baystate Health is a three-hospital system in western Massachusetts. The flagship facility, Baystate Medical Center is the only major tertiary center in a 60-mile radius.

"Our patients come here very sick. In today's healthcare environment, hospitals save people's lives but patients no longer stay in the acute care hospital long enough to fully recover. We need to make sure that when patients no longer meet the criteria for an inpatient stay that they go to a facility that can continue the plan of care and will incorporate additional focus on the recovery components of a patient's care," says **Susanna Hall**, RN, BSN, MBA, director of post-acute services at the three-hospital system in western Massachusetts.

The health system assembled a multidisciplinary post-acute performance team that began meeting with post-acute providers in the area. *(For details on how the partnership works, see related article on p. 13)*. The hospitals in the system and post-acute providers are working together to determine why patients are readmitted to the hospital and to work on ways to keep them in the appropriate level of care.

The team used the INTERACT (Interventions to Reduce Acute Care Transfers) Readmission assessment tool to collect information on hospital readmissions from skilled nursing facilities. INTERACT is a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in status of residents of skilled nursing facilities. The assessment showed that the biggest spike in readmissions occurred on Thursday and that the fewest patients were readmitted on Wednesdays. The data also showed that the majority of readmissions occur during the day shift.

The team drilled down to look for reasons and determined that readmissions are affected by the physician coverage model at the skilled facilities, reports Hall. We found that most of the readmissions are made telephonically by a physician, a physician assistant or nurse practitioner. The readmissions are lower on Wednesday because that is the day that community physicians make their rounds in the skilled nursing facilities," she says.

The team asked representatives at the post-acute facilities to review the readmissions and determine what could have prevented each individual readmission. "We are working within the structure of each organization to determine how they can improve and reduce admissions. We have asked them to look back and see if there was something they could have changed in the days before the readmission to avoid sending the patient back to the hospital," she says.

In some cases, the physicians said they weren't comfortable that the nurse who called them was aware of exactly what was happening with the patient. For instance, the nurse might see that the patient's condition was deteriorating, and talk to a physician who had never seen the patient and wasn't comfortable in adjusting the medication over the telephone.

The team encourages the post-acute providers

to take proactive steps to avoid readmissions. As a result, one facility has contracted with a telemedicine program so if there is not a physician in the house during certain hours, the on-call physician can see the patient via tele-monitor and has access to the patient's medical record from the acute stay as well as the rehab period.

In some situations, the skilled nursing staff reported that heart failure patients were being readmitted because the patient and family didn't understand the goals of care and the family had brought in a pizza or other salty food for a heart failure patient who was on a low-salt diet.

"We saw that each side could learn by sharing and developing collegial relationships. **Jodi Koshouh**, RN, the hospital's heart failure coordinator needed to learn about the constraints of a skilled nursing facility," Hall says. She arranged a roundtable discussion at the skilled nursing facility so both sides could learn and exchange best practices in heart failure management. Koshouh says: "The learning was a two-way street. We learned that skilled nursing facilities are a much different environment from the acute care hospital, in terms of the patient's right to choose. Acute hospitals can be very autocratic and vigilantly oversee every step, but when a patient leaves and is in a skilled nursing facility, it is more like their homes."

For instance, in a skilled nursing facility, patients have the option to refuse to be weighed if they want. Their diet is not as regimented as it is in the acute care hospital and if they want a salt-laden meal, they can have it. Hall says: "This was a big eye-opener for the hospital team. We have standardized the education patients and families receive at all levels of care. The more everybody gives patients the same education, the more likely they are to follow the recommendations."

Hall also works with post-acute providers to make sure that patients are not readmitted when they could receive the care they need at the skilled facility. The group talks a great deal about goals of care. For instance, a frail elder with dementia who is declining and is sent back to the acute care hospital is a common type of case. "When this patient is readmitted and ends up in the intensive care unit, the acute care practitioner often asks 'why did this need to happen,' " Hall adds. Often, the goals of care had not been clearly discussed with the family and there is a high potential that a patient could have received palliative care or hospice care at the skilled nursing facility, and experience a peaceful death, not one filled with machines and noises," Hall says. She suggests that a better solution would be to educate the family about a disease's progression and what can be done in a skilled setting long before the patient's situation starts to deteriorate.

"For some of these patients, the best care is to keep them comfortable and let them live as best they can, rather than admitting them to the ICU and putting them on a ventilator. We want to take steps in advance to help the family come to terms with their loved one's condition and not wait until there is a crisis," she says.

Alzheimer's patients are a difficult population to place, Hall points out. "It's a challenge to find the right post-acute provider," she says. As a result of the post-acute transition initiative, one of the organizations with which Hall works has opened a geriatric psychiatry unit in a local hospital. "If there is a patient with dementia in the hospital that we can't settle down, we can send him to the specialized unit. We have worked with the skilled facilities with dementia units not to send patients back to us if they have problems, but to send them to the geriatric psychiatric unit so they can receive the medication adjustment and focused clinical management they need," she says.

For instance, if a dementia patient is hospitalized, the intensity of the inpatient experience causes a lot of confusion and they may become very aggressive, creating patient safety issues. The staff at the geriatric psychiatric unit have the expertise and the resources to handle the patients' medical problems and keep their behavioral problems under control. In some cases, Hall has negotiated to have Baystate Health assist with the cost of one-on-one services for Alzheimer's patients until they settle into the new location, rather than having the patient readmitted to the acute care hospital. ■

EXECUTIVE SUMMARY

Baystate Health, a three-hospital system with headquarters in Springfield, MA, is partnering with post-acute providers to improve transitions as patients move through the continuum of care.

- A multidisciplinary post-acute performance team partnered with post-acute providers to determine why patients are readmitted to the hospital and to work on ways to avoid readmissions.
- Facilities share information with the hospitals how they operate and what they need to ensure patients receive the care they need.
- The health system's director of post-acute services holds regular meetings with providers to brainstorm on improving patient care.

Initiative creates a bridge to post-acute providers

Improving transitions is the goal

In her role as director of post-acute services for Baystate Health in Springfield, MA, **Susanna Hall**, RN, BSN, MBA acts as the bridge between the health system and post-acute providers to make sure that the post-acute providers share Baystate Health's vision of quality, to improve communication as patients transition between facilities, with the ultimate goal of ensuring that patients receive the care they need to reduce hospital readmissions.

"My role is to walk this line between the hospital and the post-acute providers and be the person who understands the need to move patients out of the hospital effectively and what the receiving providers need so we can support them. The health system created my role in 2006 to concentrate on establishing strategic initiatives to improve transitions," Hall says.

When Hall became the healthcare system's director of post-acute care, the hospital already had a relationship with a skilled nursing facility but not every patient wanted to go to that particular facility, and it didn't have the capacity to handle every patient who needed post-acute care.

"We reached out to other providers in the area, including skilled nursing facilities, inpatient rehabilitation hospitals, the Baystate Visiting Nurse Association & Hospice, and long-term acute care hospitals (LTACHs). We wanted to work together to make transfers a seamless process," she says.

Initially, Hall held strategic planning sessions with representatives of the area's post-acute providers at each level of care but determined that the process would work better if the hospital system worked with just one post-acute provider at a time.

"Everybody along the continuum is at a different place in terms of how they deliver care. They have to comply with different regulations and many have different nursing models. We had to meet each level of care at each facility where they are and work together to develop smooth transitions," she says.

The team has met with representatives of three corporations that own the bulk of post-acute facilities where Baystate Health patients receive care. "By meeting with representatives of individual corporations, rather than representatives from multiple corporations, we were able to be direct and talk frankly about our specific concerns. We talked about best practices and program outcomes and brainstormed on how to improve transitions," she says.

The hospitals and post-acute providers worked together to determine the strengths of each organization and identify opportunities for each facility. "We wanted to avoid a situation where many facilities were concentrating on accommodating the total joint patients or stroke patients," she says.

The team collaborated with the post-acute providers to determine what information providers need as patients transition from one level of care to another. "We asked our partners what information they need, how detailed it should be, and in what order. We're now in the fifth or sixth version and are still working on it," she says.

Now instead of meeting with individual corporations and providers, Baystate Health has moved the meetings with the post-acute providers into their State Action on Avoidable Rehospitalizations (STAAR) meetings. STAAR is a multi-state project sponsored by the Institute for Healthcare Improvement that aims to reduce readmissions.

The team discusses difficult cases and how they might be handled better, Hall says. "We talk about the patients who have been a challenge for everyone and learn from each other," Hall says.

The hospital system is monitoring readmissions but doesn't have any firm data to share.

"The best outcome for this initiative is that everyone is on the same team. They call me if they have a problem and I call them as well. We support each other in caring for patients and discuss what we need to do to work together for a comprehensive plan. In the end we are all working towards the same goal: helping people recover to their optimum wellness and return to living," Hall says.

SOURCE/RESOURCE

For more information, contact

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For more information on INTERACT, visit: http://interact2.net. ■

Multidisciplinary initiate cuts length of stay

CMs, RN, hospitalists collaborate on care

A multi-disciplinary initiative to make sure patients receive care in the right setting at the right time for the right reason has resulted in a

drop in length-of-stay at the two hospitals in the Memorial Health Care System in Chattanooga, TN.

In the first year, the program, called Pace of Care, has resulted in a 1.6% drop in length of stay to 4.73 days at Memorial Hospital in Chattanooga, and a 4.75% decrease to a length-of-stay of 4.02 days at Memorial Hixson Hospital in Hixson, TN. "Case managers have always known that we can't manage the care of patients alone. It takes everybody in the hospital to make sure patients get the care they need in a timely manner. We are pulling everyone on the clinical team into managing the patient," says **Demetra Reid**, RN-BC, MSHA, CCM, case management director for Memorial Health Care System.

When the initiative began, the hospital system redesigned its case management department and almost doubled the case management staff from 22 to 43. The department includes RN case managers located in the emergency department and the intake department who review direct admissions from doctors' offices and patients who are scheduled for surgery. The initiative added masters'-prepared social workers to the team. They are assisted by discharge planners, who have a bachelor's degree.

It took approximately 10 months to a year to hire, train, and provide orientation for the new case managers and social workers. Then the focus of Pace of Care switched to other disciplines involved with patient care and throughput, including nursing, hospitalists and pharmacy. *(For details on how the hospitalists and pharmacy are involved in Pace of Care, see related article on page 15).*

Case managers are assigned by unit with a goal of a caseload of 20 to 25 patients, a decline of 37 patients per case manager before Pace of Care was implemented. Social workers typically work between two units with a caseload of 40 to 50 patients, a decrease from the previous 60 to 67 patients. Discharge specialists perform routine discharge planning, leaving the social workers to work on the more complex and time consuming psychosocial issues that may arise.

Case managers, social workers, and discharge specialists use a tool that lists the majority of potential patient needs, such as assessments, durable medical equipment, arranging for skilled nursing transfers and home health services, and for delivering the Important Message from Medicare. "As the day progresses, the case managers and social workers can consult the tool and check off what has been done and what needs to be done. Proper use of this tool means the team does not have to sit down together in order to maintain constant communication throughout the day," Reid says.

A key component of Pace of Care is multidisciplinary Touch-Base Rounds led by the case manager on the unit in patients' rooms by the second day of each patient's stay. The case manager, primary nurse, and social worker/discharge specialist introduce themselves, and discuss the plan of care documented by the physician in the medical record, along with the targeted day of discharge.

"The case manager makes it clear that the date is anticipated and that the discharge could occur before or after this time period. This is a good way to get patients involved in discharge planning while introducing the concept of discharge from the beginning of the stay," Reid says.

The team writes the anticipated date of discharge on a white board in the patient's room. "This keeps everyone focused. Nursing knows when to complete the patient education and the discharge planner knows when to set up what's needed after discharge. The doctors know when we expect the patient to be discharged and it gets us past times when patients just want to stay," she says.

The rounds are informational and quick and if patients have additional questions, either the case manager, the social worker/discharge specialist, or the nurse comes back and talks to them in more detail. The team has a goal of performing additional Touch-Base rounds every other day as well as when there is a change in the patient's medical condition.

The case managers review every medical record every day to ensure that the patient status is appropriate and that they meet continued stay criteria. The case managers open the record and review the orders to ensure that the appropriate order is on the chart. "This has alleviated situations when there were not orders for patient status on the record, or to allow for swift review and resolution of criteria for the correct status assignment, such as when the status was inpatient in the computer but observation in the actual medical record," she says.

SOURCE

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Hospitalists, pharmacy collaborate on throughput

Through Pace of Care, the case management department at Memorial Health Care System in Chattanooga, TN, works closely with the hospitalist staff and the hospital pharmacy department to ensure that patients move through the continuum as quickly and safely as possible. Hospitalists care for about 60% of patients at Memorial Hospital in Chattanooga and 90% at Memorial Hixson in Hixson, TN.

Part of the efforts to fine-tune case management and hospitalist communication has been to implement case manager-hospitalist rounds, says Demetra Reid, RN-BC, MSHA, CCM, case management director. The case manager team leader or Reid rounds unit-by-unit with the director of hospitalists and discusses with the case manager on the unit, any barriers to the patient's safe and appropriate discharge. "We talk about how to expedite discharges so we can drop down our length of stay," she says. At times, the hospitalist director calls a member of the hospitalist team to discuss what clinically is taking place with patients. Other times, the case management supervisors get involved to remove barriers to discharge.

When the hospitalist rounds began, the team focused on patients who had been in the hospital 10 days or more, then began to include patients with seven-day stays. Now the rounds include patients who have been in the hospital for five days or more. "The high length of stay is decreasing which is a tribute to how effective the rounds are," Reid says.

"Communication with the pharmacy is important as there are multiple charity patients who may require medication assistance, or there are patients who could potentially go home or to a skilled level of care if their intravenous antibiotics were appropriately changed to another type," Reid says. Assistance from pharmacy has helped decrease length of stay, she adds. "Sometimes discharges are delayed because the physician orders IV antibiotics every eight hours and which would be difficult to arrange. The pharmacists may suggest appropriate alternative medications that can be given once or twice a day," she says.

Case management is a participant in a weekly high-dollar conference call with representatives from finance and the business office. The team reviews all patients whose current charges exceed $75,000, looks at the discharge plan, the anticipated discharge date insurance benefits, insurance network status, or self pay financial assistance. The team also looks at Medicare days for potential lifetime reserve days activity. "Since using Medicare life-time reserve days requires a patient's approval, this is important information to receive concurrently," Reid says.

The next layer of Pace of Care will be to develop relationships with the specialty physicians and help them understand changes in reimbursement and how they are impacting the facility. "We know that the healthcare system is evolving and that the resources are getting tighter. This means that we all have to work together to make sure patients get the care they need in an efficient and cost-effective manner," she says. ■

EXECUTIVE SUMMARY

Pace of Care, a multidisciplinary initiative at Memorial Health Care System in Chattanooga, TN, has improved patient throughput and cut length of stay.

- The case management department was redesigned and the staff increased.
- Case managers and nursing staff hold rounds in each patient's room and discuss the plan of care and anticipated discharge.
- The hospitalists and pharmacy collaborate with case management on moving patients through the continuum of care.

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 bundled payments will mean to you
- Case management beyond the hospital walls
- How ED navigators ensure appropriate admissions
- Understanding all the IMs from Medicare

CNE QUESTIONS

1. According to Deborah Hale, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, what category makes up a big portion of inpatient hospital payment errors?
   A. Wrong patient status.
   B. One-day stays.
   C. Insufficient physician documentation
   D. Wrong MS-DRG in the record

2. According to Brian Pisarsky, RN, MHA, ACM, manager in Huron Healthcare's Clinical Operations Solutions, if there is a delay in writing an order for an inpatient admission, the patient may not have a long enough stay to meet criteria for a skilled nursing stay.
   A.True
   B. False

3. What is a benchmark for the duration of observation services?
   A. 24 hours
   B. 36 hours
   C. 48 hours
   D. 60 hours

4. When patients at Port Huron Hospital don't meet criteria for an inpatient admission or observation services but need to stay overnight, their doctor can issue order for extended recovery but the hospital does not get paid.
   A. True
   B. False

CNE INSTRUCTIONS

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%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■