HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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Prepayment review pilot project recently launched by CMS

Program likely to be expanded for all Medicare claims

As part of its efforts to cut improper payments, the Centers for Medicare and Medicaid Services (CMS) has launched a three-year Recovery Audit program prepayment review demonstration project in 11 states.

The project, which began Jan. 1, 2012, means that in the future, the entire Medicare program may shift to pre-payment review says **Steven Greenspan**, JD, LLM, director of government appeals and regulatory affairs for Executive Health Resources, a Newton Square, PA, healthcare consulting firm. "The idea is to get the recovery auditors involved in doing prepayment review so CMS doesn't have to chase the money," he says.

The pilot project is being conducted in seven states with a high level of fraudulent claims, and four states with a high volume of short inpatient stays. States included because of a preponderance of fraudulent claims are Florida, California, Michigan, Texas, New York, Louisiana, and Illinois. Pennsylvania, Ohio, North Carolina, and Missouri are included because of short stays. The Medicare Administrative Contractors (MACs) are already performing a small number of prepayment audits.

EXECUTIVE SUMMARY

The Centers for Medicare and Medicaid Services (CMS) has launched a three-year Medicare prepayment review demonstration project in 11 states.

- The prepayment reviews focus on high cost procedures with a high error rate.
- The Recovery Auditors (RAs) will perform the reviews.
- If the project is successful, CMS is likely to require prepayment reviews for all Medicare claims.
- Case managers should determine the payer mix and volume for targeted procedures and ensure that the documentation meets medical necessity criteria.

Elizabeth Lamkin, MHA, chief executive officer and partner in PACE Healthcare Consulting, LLC, based in Hilton Head Island, SC, points out that the prepayment audits are expected to lower the appeal rate, lessening the burden on the provider, and saving CMS money.

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Prepayment audits may end up being positive for hospitals because they simply won't get paid up front, rather than having to go through the appeals process when claims are retrospectively denied. In addition, in the prepayment review pilot project, when the auditors determine the stay did not meet inpatient criteria, the hospitals can rebill for 90% of the prepayment review pilot project allowable outpatient claim, instead of losing entire inpatient short-stay claim.

In announcing the project, CMS said it will choose the specific claim types to review and will initially focus on inpatient claims, particularly for short stays as they have high improper payment rates. Hospitals may appeal the prepayment denials through the normal appeals process. *(For details on other changes in the Medicare audit process, see related article on page 19).*

Kathleen Miodonski, RN, BSN, CMAC, manager for The Camden Group, a national healthcare consulting company based in Los Angeles, reports that the Florida MAC has announced that pilot project will focus on 11 cardiac diagnosis related groups (DRGs), including stents, pacemaker and defibrillator implantations, and four orthopedic procedures including knee and hip replacement and spinal fusion surgery. Targets in the other states are likely to be similar, she says.

"The demonstration project is based on the premise that as many as 50% of the targeted procedures may be unnecessary, or that physicians are not accurately documenting justification for the procedures," Miodonski says.

Case managers should be aware of the payer mix and volume of the targeted DRGs at their hospital to understand the impact of the prepayment reviews, and develop preadmission and prebilling processes to make sure the medical necessity is documented on the front end and the back end, Miodonski adds. "A lot of hospitals have some form of preadmission review but there are going to be areas where additional resources need to be applied," she says.

When patients are having elective surgery, hospitals have an opportunity to make sure the documentation is in place before the patient comes in, Miodonski says. Recently, the Medicare auditors have denied some surgical procedures because the hospital's documentation did not support medical necessity,

although the documentation may have been complete in the surgeon's records. Hospitals need to establish good preadmission processes in the emergency department as well, she adds.

Case management leadership should partner with the administration and physician leaders to educate physicians about the necessity for complete documentation, Miodonski says. In addition, case managers should ensure that preadmission processes do not create delays in scheduling elective surgery, if the hospital is going to make sure the case meets criteria before the procedure is scheduled, she says.

If the auditors deny the procedure, they will issue take-back letters to physician offices and could deny payment for further outpatient care related to the hospital admission, Miodonski points out. This means that hospitals should develop good relationships with the post-acute providers in their area and make them aware that the hospital is taking steps to avoid take-backs.

"If post-acute money gets taken away because the auditors determine that the procedure didn't meet criteria, it could cause a problem with post-acute referrals going forward," she says.

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Be prepared: Medicare auditors increase scrutiny

CMS pushes contractors to be more aggressive

The Centers for Medicare and Medicaid Services (CMS) has set dollar goals and quotas for its auditors, and is holding their feet to the fire to aggressively review hospital claims, as the agency increases its focus on reducing improper payments.

In its most recent Statement of Work, CMS changed the name of the Recovery Audit Contractors (RACs) to Recovery Auditors (RAs), and expanded their scope of work to include all providers and not just acute care hospitals. The agency requires that RAs have monthly phone calls with CMS to discuss how many claims they should review, and if they don't meet their workload quota, the work may be assigned permanently to another CMS contractor, according to **Elizabeth Lamkin**, MHA, chief executive officer and partner in PACE Healthcare Consulting, LLC, based in Hilton Head Island, SC.

"We're seeing a lot of audit activity and it's likely to increase even more, putting providers under increasing scrutiny for quality and compliance. Hospitals need to make a paradigm shift in how they operate because what they have done in the past will no longer work. The hospital administration, financial staff, clinical, and medical staff must work together as equal partners to coordinate care, and ensure long-term compliance," she says.

Hospitals have a false sense of security if they feel like they are not experiencing a lot of RA activity, Lamkin says. "Not all activities are around chart review. Automated reviews take place 24 hours a day, seven days a week, and even if they are small claims, they can add up to a lot of money," she says.

CMS is encouraging its auditors to use extrapolation if they find a pattern of claims errors, she says. "Extrapolation may be cost effective for low dollar claims that require a complex review and have a high rate of error. Originally, the auditors could not recover money if the claim was less than $10. Now

EXECUTIVE SUMMARY

The Centers for Medicare and Medicaid Services (CMS) is pushing its auditors to be more aggressive in reviewing hospital claims.
• CMS has set targets for how many claims the auditors should review.
• Auditors are encouraged to use extrapolation for denials when they find a pattern of erroneous claims.
• CMS has approved more than 570 diagnosis related group (DRGs) for medical necessity review.

even small claims can be reviewed under extrapolation," she says.

Joseph Zebrowitz, MD, executive vice president, Executive Health Resources, a Newton Square, PA, healthcare consulting firm, adds that compliance is the best defense to a government audit. "Case managers should ensure that there is an excellent utilization review process in place and be sure that when the patient is discharged, the status on the chart is correct and the documentation clearly supports it," he says.

Hospitals need to be 100% concurrent in assigning status, and consistently applying InterQual and Milliman criteria, Zebrowitz says. If there are any questions about medical necessity, case managers should refer the case to the physician advisor for second level review and document it, he adds.

Hospital personnel need to be careful not to overuse outpatient status, because it is believed to be safer, or overuse inpatient status, and hope that the hospital does not get audited, Zebrowitz advises. "Program compliance must be rigorous at all times." he adds.

Case managers and physicians should be well educated on the impact that getting the status right up front can have on the patients, as well as on the hospital's bottom line, he says. "There are significant ramifications to inappropriately classifying Medicare beneficiaries as observation including cost and their right to important Medicare benefits," he says.

It's not necessary to have case managers review admissions 24 hours a day but they should conduct a review the day the patient comes into the hospital, Zebrowitz says. He reports that many hospitals have case managers in the emergency department reviewing admissions until 11 p.m.

Lamkin adds that 100% of inpatient admissions should be reviewed within 12 hours. "Complete and accurate documentation is the only thing that can help a hospital win on appeal," she says.

Steven Greenspan, JD, LLM, director of government appeals and regulatory affairs for Executive Health Resources, adds that in the demonstration project, the RACs concentrated on a relatively narrow group of medical diagnosis related group (DRGs) for complex review. Now, CMS has approved more than 570 DRGs for medical necessity, he says.

The procedures the RAs are concentrating on vary from region to region, Greenspan says. "All seem to get around to the same issues eventually, but each one has the flavor of the quarter," he says. He advises case managers to log into their RA's website to check on the focus and make sure their hospital is concentrating on the issues approved for their region, as well as checking the websites of other RAs to determine what has been approved in other regions.

Lamkin adds that the admissions care managers, and the physician advisor for case management, should work together to ensure that the bed status is correct, and that the documentation is accurate and complete.

She recommends that the admission care manager should review every inpatient and outpatient admission for appropriate bed status and place of service. Inpatient review should be done within 12 hours, and outpatient reviews before the patient receives services.

Clinical documentation specialists, typically part of the health information management department and partner to care management, should conduct ongoing chart reviews for accuracy of clinical documentation, and make queries to physicians in real time. Educate physicians on which of their charts fail to meet criteria for bed status and work with them to improve documentation on admission orders and inpatient procedures.

"Hospitals need to devote the staff needed to ensure compliance on the front end, that bed status is correct and that documentation of intensity of service and severity of illness is complete and accurate," Lamkin says. This improves coding and reduces appeals and bill holds on the back end, and reduces the time it takes to respond to RA denials, she adds.

Zebrowitz adds that hospitals should no longer think of case management as a cost center rather than a compliance center. "I'm seeing a change in thought as forward-thinking hospitals are putting more resources into utilization review, rather than decreasing staff. Hospitals that look at case management as an unnecessary expense and cut staff are going to pay a significant price," he says. ■

Discharge planning is CMS' focus

Help your hospital's HCAHPS scores

As the Centers for Medicare and Medicaid Services (CMS) continue to increase its focus on discharge planning, case managers need to pay more attention than ever to ensuring that patients have the information they need to make informed choices about their discharge destination, says **Jackie Birmingham**, RN, MSN, MS, nurse educator/consultant in discharge planning and vice president emeritus, clinical leadership at Curaspan Health Group, a Newton, MA, healthcare consulting firm.

CMS has announced its intention to add three new questions about discharge planning to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey some time in 2012. They will be in addition to the three questions regarding discharge that are part of the 27-question HCAPHS survey currently being used.

The three additional questions are:

- Did the hospital consider the patient's preferences regarding post-discharge healthcare needs?
- Did the patient understand his own responsibilities in managing his health after being discharged?
- Did the patient understand the purpose of his discharge medications?

Case managers should pay particular attention to the question on patient preference regarding post-discharge needs because they own the discharge planning process, Birmingham says. In addition they should work with the nursing staff on patient education and get pharmacists involved in medication reconciliation, she says.

"Discharge planning is the most patient-centric function in the hospital. Case managers need to talk to patients and take their specific needs and preferences into account when they develop a discharge plan," she says.

The Medicare Conditions of Participation require hospitals to provide patients with a choice of options for the appropriate next level of care. Medicare has emphasized that hospitals should give patients "real options" for post-acute services, Birmingham adds.

This means that case managers need to do more than just handing the patient a list of providers and/or asking, "what skilled nursing facility, home health, or hospice program do you prefer?" It means finding out which providers can meet the patient's needs and have beds available, and then giving them those options, Birmingham says. "Case managers should narrow the options and give patients the information they need to make an informed decision," she says.

If you ask patients for their preference, without first checking on availability, and the facility they choose isn't available, they are likely to have the perception that they are going to their second choice, she points out. In addition to affecting the hospital's HCAHPS scores, in some cases, it could affect readmissions, she says. "When patients feel like they had to take their second choice for a post-acute provider, and they don't like their room or the food, they may insist on going back to the hospital," she says.

The HCAPHS scores are important to hospitals because the results are publicly reported data that may affect referrals and patient choice, Birmingham says. In addition, in the future, under value-based purchasing, a percentage of Medicare reimbursement is going to be based on the HCAHPS scores," she says.

Birmingham suggests that case managers receive training on communication, interpersonal skills, and how to talk to people who are sick, to find out their post-discharge needs and preferences. "Hospitals need a communication specialist to work with case managers who do discharge planning and teach them how to ferret out the real issues patients have," she says.

EXECUTIVE SUMMARY

The Centers for Medicare and Medicaid Services (CMS) has announced its intention to add three new questions about discharge planning to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey in 2012.

- Case managers should make sure that patients have a choice of options for the next level of care.
- Make sure there are beds available and then give the patients a list of appropriate provides from which to choose.
- HCAHPS scores are increasing in importance as CMS moves to value-based purchasing.

Hospitals need to develop a way to identify appropriate and available beds in real time so the discharge planners can give patients viable options, she says.

Keep in mind that it is permissible for case managers to include post-acute services owned by the hospital in the list of options for patients as long as they tell the patient that there is a financial interest, she says. "Hospital case managers must look at what is best for patients, as well as the business interest of the hospital and to do that, the entire team needs to sit down and develop an effective mechanism for giving choices to patients," she says.

Get ahead of the curve by finding out patient complaints about their discharge and their discharge destinations, and determine what is working well and what needs to be improved, she says.

Look at your hospitals existing HCAHPS scores for discharge-related questions. "If a hospital is trending low, it's likely the trend will continue with the new questions," she says.

Take time to talk with patients about the next step in the treatment process. Answer their questions and listen to their concerns, she says.

SOURCE

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ED Navigators prevent unnecessary admissions

RNs help connect patients to community resources

By identifying community resources for homeless and near-homeless patients, Montefiore Medical Center in the Bronx, NY, is cutting down preventable admissions.

Nurse case managers act as patient navigators in the emergency department and work closely with emergency department social workers to prevent unnecessary admissions. Social workers cover the emergency department 24 hours a day, seven days a week. The emergency department navigators work from 9 a.m. to 7 p.m.

EXECUTIVE SUMMARY

RN Navigators in the emergency department at Montefiore Medical Center work with social workers to prevent unnecessary admissions.

• Program targets the homeless and patients with tenuous living situations.

• CMs work with the emergency department staff to identify patients who don't meet admission criteria but can't be safely discharged.

• The hospital collaborates with a local housing assistance agency which sends a van to transport appropriate patients to a shelter.

The hospital met its goal of 3,000 fewer admissions in 2011 than in 2010, according to **Anne Meara**, RN, MBA, assistant vice president for network care management for the 1,491-bed medical center. "It's hard to separate the outcomes for the navigator program from other initiatives but it is one of the things that have contributed to our reduction in readmissions," Meara says.

The navigators work with patients who utilize the emergency department for a variety of reasons. Some have significant medical conditions in addition to complex psychosocial issues. Others have behavioral and substance abuse issues in addition to the medical problems.

The hospital is located in one of the poorest counties in the country, and 80% of patients are covered by Medicare or Medicaid. "Many patients are pre-homeless, and the attending physicians may plan to admit them because they do not feel comfortable sending them out without a definite place to go," Meara says.

When patients who are at high risk for a preventable admission come into the hospital, the registration system alerts the emergency department navigator and social worker. Patients who meet criteria for an intervention include patients who were discharged from the hospital in the past 30 days, or have had five emergency department visits in the last year, those who are homeless, living in a shelter, or who have tenuous housing situations.

The navigators often meet with the patient before he or she is evaluated by the physician. They work with the physician to determine

CASE MANAGEMENT INSIDER

Case manager to case manager

A further look into case management roles, functions, models, and case loads

By **Toni Cesta**, PhD, RN, FAAN
Senior Vice President
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In the last two issues of *Case Management Insider*, we reviewed the roles and functions most often associated with the work of case managers in the acute care setting. In this issue we will discuss the ways in which these roles and functions can be combined to create the most effective and efficient model for any hospital or healthcare setting. We also will discuss the state-of-the-art staffing ratios needed to support the various models.

The history of case management models

The prospective payment system for Medicare patients initiated the need for hospital staff to begin to think differently about how they organize and deliver care. Because hospitals would now be paid one fee for the entire stay, managing length of stay and cost containment became new necessities for hospitals. Gone were the indemnity reimbursement methods under which hospitals had operated. Under the old payment schemes, hospitals were paid equally for services rendered, usually with little questions asked. With the advent of prospective payment and diagnosis related groups (DRGs), the federal government had essentially put hospitals on a budget, paying them a flat fee for the hospital stay, also known as a case rate payment. It was believed that this type of payment scheme was to provide incentives to hospitals to become more efficient, thereby lowering costs and length of stay.

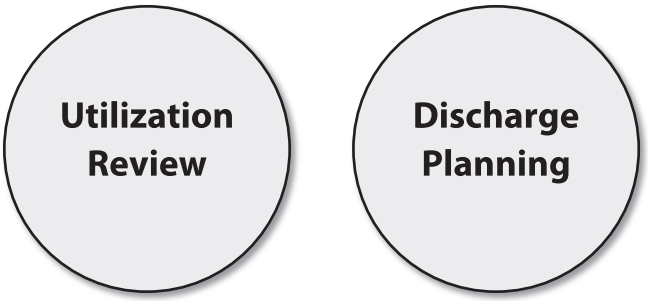
The logic behind prospective payment systems that drives the need for hospitals to become more efficient is that the hospital is able to deliver the care, and spend less than the fixed reimbursement amount, then they get to keep the surplus. Conversely, if the hospital spends more than the fixed reimbursement amount, then they have to absorb that additional cost. The goal is to ultimately balance out all costs, knowing that some patients will cost more than the reimbursed amount, and some less.

Following Medicare's reimbursement changes, many states adopted similar case rate methodologies for their Medicaid programs. Within a few years, as healthcare costs continued to rise, managed care organizations began to offer healthcare benefit packages to employers at lower premium costs than had been offered under the indemnity programs. Although managed care had been around for decades, it wasn't until the later 1980s that it began to become increasingly popular. Its popularity correlated directly with the rising costs of healthcare throughout the United States. With increasing percentages of managed care penetration, a continued focus on length of stay management and cost containment remained critical to the financial viability of hospitals.

It became clear that modifications to the existing delivery methods that preceded prospective payment were essential. With this began a significant shift in how hospitals viewed case management, and many hospitals began to develop some version of a case management model at that time. There were no national standards for case management roles, functions, models, or staffing ratios yet. Each hospital attempted to take their existing structures and modify them in some way.

Most hospitals started with the traditional case management models which were a combination of utilization review and discharge planning. Utilization review, performed by nurses, was separate from discharge planning, performed by

Traditional Case Management Model



social workers. The two roles did not intersect and had little to do with each other. In fact, prior to the introduction of prospective payment and managed care, there was little need for an integrated approach to these functions. Once the reimbursement structures changed, the delivery models also had to change. ■

Partially integrating models and roles

By **Toni Cesta**, PhD, RN, FAAN
Senior Vice President
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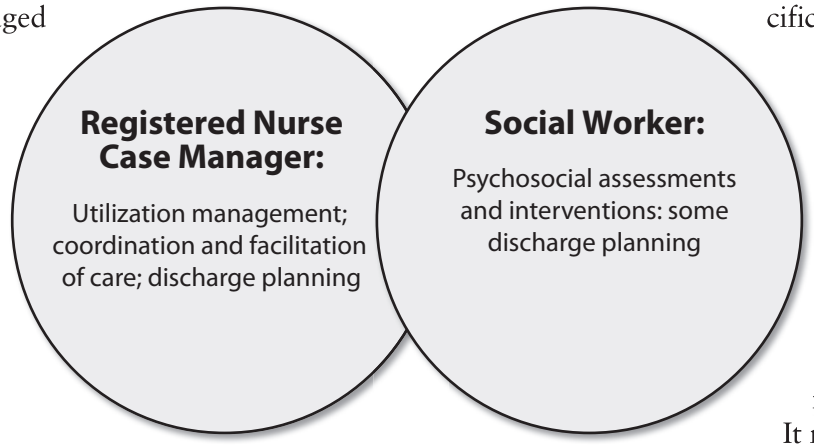
Brooklyn, NY

At this point, some hospitals began to attempt to interface the roles of utilization review and discharge planning. These models began to integrate the previously disconnected roles of utilization management and coordination and facilitation of care with discharge planning. These roles began to intersect with discharge planning, which was managed by social work in the early models.

As discharge planning began to become more complex, and as patients' psychosocial issues needed to be addressed, a shift began to take place in the management of the discharge planning processes. Some hospitals began to consider moving some of the discharge planning functions to the nurse case manager, so that the social worker could spend more time dealing with the patient's psychosocial issues. At the same time, this would allow the nurse to manage more clinically complex discharge planning activities, such as home care placement, sub-acute and home infusion therapy. The need to relate patients' clinical issues to their level of care and their discharge plan, drove this change forward. In addition, the continuum of care was becoming more robust, with ever increasing options available beyond the walls of the hospital. Care began to shift to the out-patient environment with an explosion in home care agencies, infusion companies, as well as the use of sub-acute and ambulatory surgery. By the mid-1990s hospitals began to move toward more fully integrated models. Today, we see a variety of models that have been adapted to the specific needs of organizations. However, there are some fundamentals to any model that should be used. Adaptations can be made to these fundamental core roles. ■

Partially Integrated Model



The state-of-the-art in CM models

By **Toni Cesta**, PhD, RN, FAAN
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Today, we see two basic versions of case management models: the integrated (dyad) model and the collaborative (triad) model. With each of these foundational models hospitals can add the additional roles that they require to meet their specific needs.

- **The integrated dyad model.** The integrated model represents a fully integrated model in which all core functions of case management are under the responsibility of the nurse case manager. It represents one of the state-of-the-art models in

use today. In this model, all case management roles are performed by a single case manager. The model integrates all previously disconnected roles and functions. In the integrated model, the nurse case manager and social worker collaborate on the most complex cases.

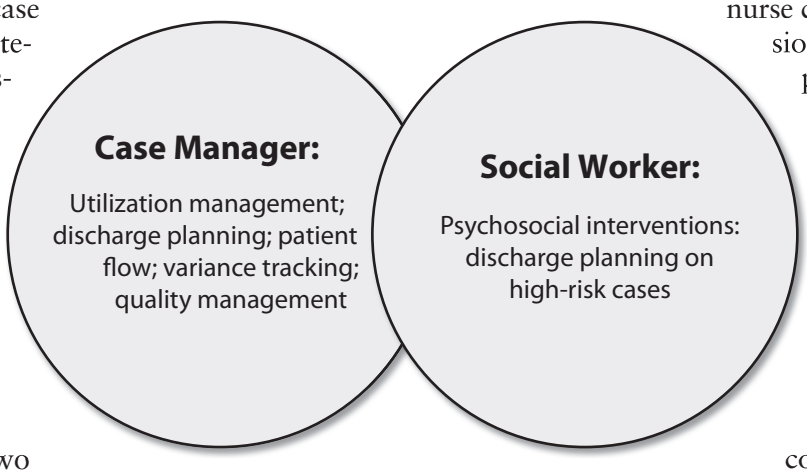
Case managers working in this type of structure manage the patients in one of two ways. Either all the patients have a case manager assigned to them, or some do, based on pre-determined selection criteria. Today, the state-of-the-art model is to have all patients assessed and followed by a nurse case manager. Selecting only some patients for case management may result in patients falling through the cracks and ultimately not receiving the post-acute care services they may need.

However, in this model, not all patients will need to be followed by a social worker. The patients that will be followed will depend on the hospital's high-risk criteria that they select to help identify those patients who would benefit from social work services. These criteria should be prospectively determined and understood by the case management team, as well as the other disciplines such as physicians and nurses. If not well understood, this can result in unnecessary referrals being made to social work, and additional work placed on the social worker to screen these patients out.

In the dyad model, the case manager is responsible for some additional roles and functions. These include the addition of discharge planning and variance management.

In the dyad model, the social worker may be responsible for some of the discharge planning functions, or may be solely responsible for psychosocial assessments and interventions, with discharge planning completely under the responsibilities of the nurse case manager. The decision to share the discharge planning functions is that of the hospital, and has to be carefully considered. Things to be considered would include the types of patients the hospital typically cares for. If the hospital deals with highly psychosocially complex patients, then some consideration should be given to how the work is allotted to each discipline.

Integrated Dyad Model



The average hospital should expect to have 30–40% of their patients followed by a social worker as these are the average percentages of patients that will typically match high-risk referral criteria. The role of the social worker will be discussed in more detail in a future issue.

The integrated model is designed to allow for the division of discharge planning functions based on the issues that the patient presents with. Simply stated, the nurse case manager takes responsibility for the functions associated with discharge planning that are more clinical in nature, and the social worker takes responsibility for the function of discharge planning that are more psychosocial in nature.

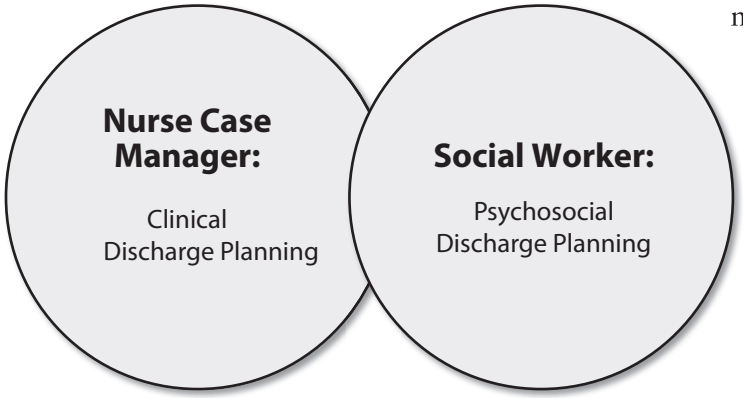
• **The collaborative (triad) model.**

The collaborative or triad model adds a third key player to the core case management team. In this model, the clinical and business functions of case management are separate roles with three team partners actively working together. The case manager is not responsible for the business functions which are defined as: Utilization management: Obtaining authorizations, managing observation status, and denial management.

• **Clinical documentation improvement.**

These roles are performed by the third member

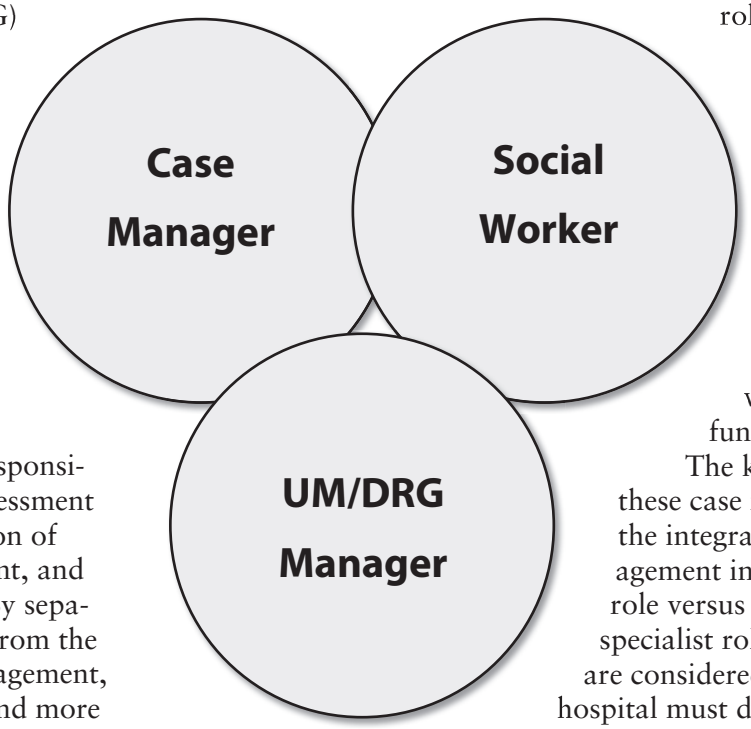
Dyad Model



of the team, the Utilization Management/Diagnosis Related Group (UM/DRG) manager. The UM/DRG manager primarily works the business side of case management, including intense review of documentation. The UM/DRG manager is the liaison between the team members and the regulatory and payer entities.

The case manager is responsible for risk screening, assessment and planning, coordination of care, resource management, and outcomes management. By separating the business roles from the clinical roles of case management, the case manager can spend more time dealing with complex clinical issues instead of payer or reimbursement issues.

The Collaborative Triad Model



In this model, the social worker performs very similar roles and functions as in the integrated model. These include screening of patients, assessment and planning, brief therapeutic interventions, care planning, and crisis intervention. For high-risk cases, the social worker assists with discharge planning functions as needed.

The key difference between these case management models is the integration of utilization management into the case manager role versus a separate UM/DRG specialist role. Since both models are considered state-of-the-art, each hospital must determine which model will best help them achieve their expected outcomes. ■

Pros and cons of CM models

By **Toni Cesta**, PhD, RN, FAAN
Senior Vice President
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All models have advantages and disadvantages. The decision to select one model over another will depend on many factors that must be taken into consideration. To aid in the decision making process, below is a table outlining the advantages of each model. ■

Advantages of Integrated v. Collaborative Model

Integrated Model	Collaborative Model
Everything under one umbrella.	Consolidates business functions of case management into one role- builds expertise.
Reduced duplication, fragmentation and redundancy.	Case managers not consumed with routine payer functions.
Data collected once for multiple purposes.	Case managers have time to focus on more leveraged functions.
Case manages in direct communication with third-party payers and vendors — they know the case.	Expanded focus on documentation review and improvement.

Disadvantages of Integrated v. Collaborative Model

Integrated Model	Collaborative Model
Bundles highly time-dependent functions [discharge planning and utilization management]. Can be frustrating for sta—to manage.	Requires intensive communication between triad members.
If not done well, can morph into a set of tasks rather than an integrated approach to the roles and functions.	Creates some duplication. The utilization manager and case manager are reviewing the chart for similar or same information.
Detail work of UM may appeal to some sta—more than other aspects of case management.	Works best if all disciplines report to the same administrator.
Will not work if sta› ng is inadequate. Infrastructure will crumble.	May be more costly and require more sta—members.
	Will not work if sta› ng is inadequate. Infrastructure will crumble.

an alternative to hospitalization by arranging services in the community, Meara says. "We emphasize to the emergency department staff that we are not telling them not to admit patients if they need it, but that we are working with them to provide resources to prevent unnecessary admissions," she says.

For instance, when a woman brought in her mother after a fall, the emergency department navigator intervened and was able to get her admitted to a skilled nursing facility, rather than being admitted to the hospital which was the original plan.

In the past, some patients were admitted for brief periods of time because they had psychosocial problems that were too complex for the staff to handle in a short time. The program helps get them connected to the right services in the community.

"By introducing this program into the emergency department, we have educated the emergency department staff to address more than just the medical complaints, and to look at other factors that are responsible for patients making multiple visits to the emergency department, and work with the navigators to find alternatives to admissions," she says.

Most of the patients who are referred to the program have housing issues. The case manager navigators work closely with a community-based housing assistance organization that has a variety of levels of care and programs including shelters for individuals, and family shelters. When the physician is considering admitting patients because they don't have a place to go, the navigator contacts the organization which sends a van to transport the patients to a residential facility and works with the navigator to arrange follow-up medical care.

The navigators have monthly meetings with the housing assistance organization, and reviews the cases both are working on. "They utilize our healthcare system and help us with finding placement for our patients," Meara says.

If someone is in a shelter, it's difficult to coordinate their care, Meara points out. For instance, one patient gets primary care in an ambulatory setting but also comes to the emergency department frequently. The navigator team is working with the staff at the shelter to ensure that the patient gets the care he needs in an appropriate setting. Another patient comes to the emergency department to get insulin because he doesn't have access to proper storage facilities in the shelter. "We're working with the shelter to come up with a solution," she says.

The nurse navigators are also partnering with the local skilled nursing facilities so if they send patients to the emergency department for issues such as chest pain, the patients can return to the facility after workup and treatment, rather than being admitted to the hospital.

"Over time, the program is evolving to address a number of issues that in the past, typically resulted in an admission. Now, because the emergency department staff understands the role of the navigators, we can avert those admissions," Meara says.

Some admissions are not preventative because patients have complex medical conditions that require a hospital stay, Meara says. "But by having case managers in the emergency department collaborating with the clinicians and providing feedback to the people who take care of the person in the shelter, we can establish continuity in care across settings and into the community. This program has played a significant role in changing the mindset of the emergency department team. It's given them the confidence and comfort level to discharge people back to the community when resources are in place," she says.

SOURCE

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Visits keep frail elderly out of hospital

Model integrates care across the continuum

Frail elderly patients are able to stay in their homes, thanks to home visits by an interdisciplinary team from Boston University's Geriatric Service at Boston Medical Center.

The home visits are part of an integrated model of care across sites of care, including a geriatric outpatient clinic, a nursing home pro-

EXECUTIVE SUMMARY

An interdisciplinary team from Boston University's Geriatric Service provides home visits for frail elderly patients who are homebound.

- The home care team includes a nurse case manager and a board-certified geriatrician.
- Physicians visit the patients every two or three months. Case managers visit as needed.
- Case managers use creativity to come up with ways to keep the elderly at home, including providing pest control, air conditioners, or chair lifts.
- The program coordinates care across sites of care, including a geriatric outpatient clinic, nursing homes, and an inpatient geriatric service, as well as the home visits.

gram (both sub acute and long-term care) and an inpatient geriatric service staffed by geriatricians, nurse practitioners, and a discharge planner, according to **Maureen Russell**, RN, BC, MPH, CCM, a certified geriatric nurse and nurse case manager in the Geriatrics Home Care Program.

The Home Care Program provides care for homebound patients age 70 and older who live in the Boston inner city. Many are low income and non-English speaking, and uninsured or underinsured. The majority are female who rely primarily on Medicare. Some are dual eligible and receive Medicare and Mass Health, the state's Medicaid program.

Pat Takach, RN, MA, home care nurse case manager says that each home care team includes a nurse case manager and a board certified geriatrician and is assigned to a particularly geographic area. Physicians visit the patients every two to three months, depending on the patient's preference and condition. The case managers often see their patients frequently at first, then as needed. The case managers complete a geriatric nursing assessment on the first visit and assess the home environment, barriers to safety, social support, pain issues, and potential for falls. "The first real issue is to look at the medications for duplications and work with the geriatrician to consolidate them, and limit the number of times a day the patients have to take their medication. We also conduct medication reconciliation at every visit," Takach says.

If the patient can manage taking their own medications, the case managers may suggest using medication planners set up for a week or two at a time. They work with the caregivers to ensure medication adherence.

The nurse care managers think outside the box to come up with ways to help the patients stay at home, minimize hospital admissions or transfers to an extended care facility. For instance, they have arranged pest extermination services, purchased durable medical equipment, arranged homemaker services, and arranged installation of air conditioners in the homes of patients with chronic obstructive pulmonary disease. For one elder who could not negotiate the stairs to her third-floor walk-up apartment, the case manager arranged for installation of a chairlift.

One patient who is completely deaf requires anticoagulation therapy. The case manager installed a fax in the patient's home in order to communicate blood thinner dose adjustments efficiently. The nurse practitioner and the case manager take turns going to the patient's home and filling the pill box with doses of blood thinner based on her International Normalized Ratio (INR) levels.

The ultimate goal is to keep the patients in their homes as long as possible and to support them and their families as they move through the continuum of care. Recognizing that caregiver stress can be a real problem, the case managers encourage self-care for caregivers. For example, they may arrange adult day care services and transportation to minimize caregiver burnout.

"Many patients are being cared for by adults who are older than 70 themselves, and have their own medical problems, along with the responsibility of taking care of their parents. We evaluate the caregivers for services, as well and get them help when they need it," Takach says.

The case managers typically carry a caseload of about 100 patients. They usually visit their patients two days a week, often accompanied by medical students from Boston University School of Medicine. The remainder of the week, they work on service coordination, phone calls, research projects, and lectures for students. They attend Friday morning educational conferences with the entire clinical staff in Geriatric Service to keep staff up to date on best practices.

Russell adds: "We stay with our patients for life. We try to stay ahead of the curve and

prevent readmissions and keep the patients safe at home. When we can keep the patient in their home, the patient is happier, the family is happier, and it reduces costs to the healthcare system."

SOURCE

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Collaboration is key to managing seniors

Program extends across levels of care

Frail elderly patients are vulnerable for exacerbation of their conditions and readmissions to the hospital as they transition between levels of care, points out **Maureen Russell**, RN, BC, MPH, CCM, a certified geriatric nurse and nurse case manager in the Boston Medical Center Geriatrics Home Care Program.

The Geriatrics Home Care Program is part of Boston University Medical School's Geriatric Service, which provides integrated care management for seniors in the geriatric inpatient service and outpatient clinic at the Boston Medical Center, in area skilled nursing facilities, or in their homes. "Patients tend to move among our four sites of care as conditions indicate. Many start receiving services in the geriatric clinic, and as they become more fragile and perhaps homebound, they receive home care from geriatricians and case managers. If they are admitted to the hospital, they may be discharged to one of the 10 nursing homes we serve. Clinicians at all levels of care collaborate to ensure that the patients get the care they need," Russell says.

The home care program is staffed by six nurse care managers who work closely with geriatricians and precept fourth year medical students from Boston University School of Medicine. The geriatric clinic is staffed by two nurses specializing in geriatrics. Five geriatric nurse practitioners see patients in the skilled nursing facilities.

The service is available to patients 24 hours a day, seven days a week. The hospital operator answers the program phone after hours and pages the geriatrician on call.

The geriatric inpatient team follows patients in need of acute care. When patients are discharged, they transition to the home care program, the skilled nursing facility team, or an outpatient clinic, depending on their needs, Russell says. When patients are discharged to their home, a resource nurse makes a follow up call to review the discharge plan. If patients are discharged to a skilled nursing facility, a nurse practitioner or physician sees them within two days.

The home care case managers work closely with the skilled nursing facility program which includes a geriatrician and a geriatric nurse practitioner, as well as the treating team at the geriatric clinic and the hospital-based geriatric team. When patients are ready to return home, the skilled nursing team coordinates the discharge with the home care case managers.

Pat Takach, RN, MA, home care nurse case manager says: "Many times, it's difficult to discharge frail elderly patients back into the community. If the nursing facility questions whether the senior could be safely discharged, we go to a family meeting and discuss the best plan with the nursing facility staff." The program has a palliative care component which the case managers can call on to help managing the patients' care when appropriate.

On Fridays, the entire clinical staff in the Geriatric Service meets formally and informally to discuss patients, brainstorm solutions to difficult cases, and share information about the patients who are transitioning between sites of care. For instance, if a patient is leaving the hospital and going home, the physician discusses the case with the care manager who is better prepared for the home visit." Russell adds: "The meetings help us improve transitions between levels of care by making sure everyone is on the same page and facilitating communication between the teams." ■

Project reviews admissions up front

Goal is to get the status right

As part of the efforts to ensure that admissions are appropriate, Covenant Health System, with headquarters in Knoxville, TN,

EXECUTIVE SUMMARY

Covenant Health System is conducting a pilot project in which utilization managers review all patients admitted to the hospital and work with the physician to determine bed status.

- The team works in a centrally located access center from 6 a.m. to midnight and reviews cases admitted overnight each morning.
- The program allows emergency department case managers to concentrate on patients who do not meet criteria, and the unit case managers concentrate on care coordination.
- The team facilitates conference calls between the admitting physician and the physician transferring a patient from another hospital.

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is conducting a pilot project to test the effectiveness of having utilization managers review patients admitted to the hospital, and work with the admitting physician to decide whether the patient should be admitted or receive observation services as an outpatient.

In the pilot project, the utilization managers are reviewing the cases of Medicare patients in two hospitals in the seven-hospital system. Plans are to expand the program in 2012, according to **Teresa Fugate**, RN, BBA, CCM, CPHQ, vice president, case management services for the hospital system. "Our goal is to get patient status correct at the time of admission, rather than reviewing the cases 24 hours later and making changes on the back end. We are working to place people on the front end to help the admitting physicians in the decision-making process," she says.

The utilization managers staff a centrally located access center from 6 a.m. to midnight. Each morning the access center staff reviews the cases admitted from 12 midnight to 6 a.m. to make sure the patient status is correct. Having the access center review patients for medical necessity saves time for the case managers in the emergency department and on the hospital unit, giving them time to concentrate on other matters, Fugate says.

Case managers at all seven hospitals staff the emergency department during peak times. "When the emergency department case managers do not have to review patients for medical necessity, they are able to work with patients who do not meet criteria, to line up whatever support and services they may need, avoiding social admissions when the patients can't be safely discharged otherwise. We believe this initiative will save the unit case managers time because they can concentrate on care coordination and discharge planning, while the utilization managers review the records of the patients admitted overnight for medical necessity," she says.

The utilization management specialists have a clinical background and are trained in medical necessity criteria, and use of the health system's case management software. They are overseen by a RN. They are part of the case management department and attend all department meetings and training.

The access center utilization managers review patient information and admission criteria and provide advice to physicians to help them make decisions on whether the patient should be admitted, or receive observation services as an outpatient. If the patient's condition doesn't meet admission status and the admitting physician disagrees, the utilization manager can refer the case to the physician advisor for case management, and if necessary, have it reviewed by an external physician advisor company with which the hospital system contracts.

When patients are being transferred from other facilities, the utilization managers gather as much information as possible before the patient gets to the door to assist the emergency department physicians in determining if the patient meets inpatient criteria.

The access center staff facilitates and records a three-way call between the hospital's admitting physician and the referring physician, to discuss the condition of the patient. "We can't make a decision on patient status based on verbal information, but we do get enough information to start thinking about the status and whether the initial information indicates that the patient will meet medical necessity," Fugate says.

Once the patient gets to the hospital and has been seen by a physician, the access department staff reviews the additional information the emergency department physician has dictated, including the history and physical orders, and medications prescribed, and assists the attending physician on determining whether the patient meets inpatient criteria or is more appropriate for observation services.

All admissions to the two hospitals in the pilot go through the access center. "Like all other hospitals, our admissions are now being scrutinized by the Recovery Audit Contractors (RACs) and other auditors, and it's crucial that we get medical necessity and patient status right at the time the patient comes to the facility. The access center and upfront utilization management are helping us do this," Fugate says.

SOURCE

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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

■ Ways your peers are preventing readmissions.

■ How to prove the value of case management.

■ Techniques for recruiting and training staff.

■ Making sense of the IMs from Medicare.

CNE QUESTIONS

1. According to Kathleen Miodonski, RN, BSN, CMAC, manager for the Camden Group, Florida's Medicare Administrative Contractor (MAC), has announced 15 targeted DRGs for Medicare's prepayment demonstration project in Florida, and other states are likely to have similar targets. What types of DRGs are targeted in Florida?
   A. Cardiac and orthopedic procedures.
   B. Heart failure and chest pain DRGs.
   C. Pneumonia and asthma treatment.
   D. Syncope and dehydration.

2. Elizabeth Lamkin, MHA, chief executive officer and partner in PACE Healthcare Consulting, LLC, recommends that 100% of all admissions be reviewed within what timeframe?
   A. Before the patient is admitted.
   B. Within 12 hours after admission.
   C. Within 24 hours of admission.
   D. At least 12 hours before discharge.

3. True or False: According to Jackie Birmingham, RN, MSN, MS, nurse educator/consultant in discharge planning and vice president emeritus, clinical leadership at Curaspan Health Group, in order to comply with Medicare's Conditions of Participation, case managers should hand patients a list of post-acute providers or ask "what skilled nursing facility, home health, or hospice program do you prefer?"
   A. True
   B. False

4. What hours do emergency department navigators cover the emergency department at Montefiore Medical Center?
   A. 24 hours a day.
   B. 7 a.m. to 11 p.m.
   C. 9 a.m. to 7 p.m.
   D. 8 a.m. to 5 p.m.