HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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Get ready for more headaches as Medicaid RACs are ramped up

Details are uncertain but challenges abound

If you thought the Medicare Recovery Audit (RA) program was problematic, just wait until the Medicaid Recovery Audit Contractor (RAC) program goes into high gear.

The Centers for Medicare and Medicaid Services (CMS) instructed state Medicaid agencies to develop a RAC program by Jan. 1 of this year but the program is not expected to be in full swing until well into 2013.

The Medicaid RAC program is likely to be more challenging than its Medicare counterpart because the final rule for the Medicaid program is not as detailed as the Medicare final rule and individual state Medicaid agencies have a lot of leeway in creating their own RAC process, says **Elizabeth Lamkin**, MHA, chief executive officer and partner in PACE Healthcare Consulting, LLC, based in Hilton Head Island, SC. "There was a steep learning curve for providers with the Medicare program and the Medicaid program may be more problematic because there are so many vendors and different state rules," she says. The only bright spot is that Medicaid HMO patients will not be subject to the Medicaid RAC, she adds.

Deborah Hale, CCS, CCDS, president and chief executive officer of

EXECUTIVE SUMMARY

The Medicaid Recovery Audit Contractors (RAC) program is going to be a challenge for hospitals because each state has a different set of rules, different auditors, and different appeals processes.

- Since Medicaid agencies are always short of funds, the auditors are likely to be aggressive.
- Case managers must review all patients at point of admission, apply the same criteria, and make sure that documentation is detailed and complete.
- If a hospital treats patients from more than one state, case managers need to be familiar with the rules and regulations of each state's Medicaid program.
- Medical necessity for one-day stays is likely to be a major focus of the Medicaid RACs.

Administrative Consultant Service, a healthcare consulting firm based in Shawnee, OK, adds that it's impossible to make a lot of general statements about the Medicaid RACs because each state Medicaid agency does things so differently. Hospitals are challenged because every state can have different rules for payment, and it's often difficult to know what the rules are, Hale says. "I have worked with clients in one state that has five different Medicaid HMOs and every one had different rules, and often they weren't very clear or detailed. Case managers were spending all their time trying to keep up with certification and recertification," she says.

CMS has given the states the leeway to use their current Medicaid appeals process or create a different one for the RACs. "If a hospital gets patients from multiple states, the staff will have to deal with multiple Medicaid RACs, different rules and appeals processes, and it can get very confusing," Hale says.

Children's hospitals and public safety net hospitals are likely to be hardest hit by the program, she says. The Medicaid RACs are likely to be particularly aggressive since Medicaid agencies throughout the country are perennially short of funds and are always looking for ways to recoup money, she adds.

Joanna Malcolm, RN, CCM, BSN, consulting manager, clinical advisory services for Pershing, Yoakley & Associates in Atlanta, advises case managers to give the same scrutiny to Medicare beneficiaries, Medicaid patients, and those who are self-pay, because they have the chance of becoming eligible for Medicaid. "Hospitals have a lot to lose if they don't pay attention to all of the government auditors and take steps to avoid having revenue taken back. It's important for case managers to treat all of these patients the same way and apply criteria in exactly the same way," she says.

Hale points out that the CMS Conditions of Participation rules for Utilization Review apply to Medicare and Medicaid patients. The CMS publication also states an expectation that case managers are to screen patients at the point of entry. "Case managers should review cases for medical necessity and time of admission and try to provide guidance for the medical staff," she says.

Lamkin asserts that admissions case managers, who review every admission for appropriate medical necessity, bed status, and place of service, must know the Medicaid billing rules. "The case manager needs to be well-versed in Medicaid regulations because hospitals must be extremely careful in documenting the approval for level of care for these patients," she says.

Case managers should work closely with the physician advisor and the clinical documentation specialist to make sure every admission meets medical necessity and that the bed status and place of services are appropriate, and that it is documented, she says. If there is any question, case managers and/or their physician advisors should contact the Medicaid RAC medical advisor for guidance and be

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very careful about documenting the conversation, she says. "Documentation is the only way to defend the services provided to the patients, and to bill appropriately," she says. *(For more information about RAC and medical necessity, see story, right.)*

If case managers are using evidence-based medical criteria and are consistent in the way they manage the episode of care and document thoroughly, the hospital is more likely to be in good shape when the RACs review the Medicaid records, Lamkin adds. "If the front end documentation is appropriate and based on criteria, you can appeal under whatever appeals process your state establishes," she says.

Hale adds that getting medical necessity and patient status right up front is crucial to avoiding take-backs from the Medicaid RACs. "In my experience, it's been much more difficult to get a Medicaid denial overturned than to successfully appeal a Medicare denial," she says.

Lamkin predicts that tracking Medicaid RAC records requests, denials, and appeals will be a nightmare for providers serving patients in multiple states. "We know the appeals process has been the most difficult area for providers in the Medicare program and we expect the same in the Medicaid program," she says.

Nevertheless, hospitals should appeal their denials, and keep appealing, Lamkin says, pointing out that during the Medicare demonstration project, many denials were not overturned until the third level of the appeals process. Track the denials that are not appealable and use them as basis to educate the staff, including physicians.

Malcolm points out that unlike Medicare RACs that have focused on inpatient claims, Medicaid RACs are going to take a broader scope and identify inappropriate payments for outpatient services, as well as post-acute providers. Case managers should work closely with home health agencies, skilled nursing facilities, and other post-acute providers to develop plans for making sure Medicaid patients get the care they need, Malcolm says.

"Hospitals need to start early to develop relationships with these providers. Everybody wants the paying patients, but communities need to do something for patients who can't pay. The Medicaid RACs are going to be looking at providers at all levels of care so we all need to work together," she says.

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• To learn the status of the Medicaid RAC program in your state, visit: https://www.cms.gov/medicaidracs/home.aspx.
• Final rule - 76 *Fed Reg* 57808 (Sept. 16, 2011). Website: http://www.gpo.gov/fdsys/pkg/FR-2011-09-16/pdf/2011-23695.pdf. ■

Medical necessity likely RACs focus

Short stays likely to be denied

It's too early in the game to know exactly where the Medicaid Recovery Audit Contractors (RACs) are going to focus, but hospitals can take a lesson from their experiences with the Medicare Recovery Audit (RA) program, says **Joanna Malcolm**, RN, CCM, BSN, consulting manager, clinical advisory services for Pershing, Yoakley & Associates in Atlanta.

She predicts that the Medicaid RACs will start looking for medical necessity issues, following the lead of the Medicare RAs. "Medicare has recouped a lot of money from medical necessity review, and the RACs are going to look where the money is," she says.

Elizabeth Lamkin, MHA, chief executive officer and partner in PACE Healthcare Consulting, LLC, based in Hilton Head Island, SC, adds that the Medicaid RACs are likely to focus on many of the same issues as the Medicare RAs such as short length of stays, medical necessity for the inpatient setting for chest pain, syncope, transient ischemic attack, abdominal pain, back pain, and short stay surgery such as laparoscopic procedures, coronary artery stents and genitourinary procedures.

Since the RAC program began in January, Lamkin has received some anecdotal information from clients in Colorado that the Medicaid RAC's focuses for denials were very different from those of the Medicare RA. "When the Medicaid RACs have issued denials for medical necessity, they've been issuing them for different reasons that the Medicare RAs," she says.

Deborah Hale, CCS, CCDS, president and chief executive officer of Administrative Consultant

Service, a healthcare consulting firm based in Shawnee, OK, adds that denials are likely to occur when the documentation does not support the DRG coding and when patients are readmitted after being prematurely discharged. Historically, Medicaid agencies have placed more focus on expected length of stay than on medical necessity, Hale says. If the expected length of stay is less than 24 hours, providers are not likely to get the admission approved even if it meets inpatient criteria, she says. If a patient is not listed on the midnight hospital census, an inpatient claim for that one-day stay is likely to be denied, she adds.

Charleeda Redman, RN, MSN, ACM, executive director of corporate care management for the University of Pittsburgh Medical Center, an integrated care delivery system with headquarters in Pittsburgh, PA, adds that the same vendor Pennsylvania Department of Public Welfare has chosen for the Medicaid RAC program, has been performing retrospective audits of the hospital's Medicaid records for five years. The auditor focuses on medical necessity for one-day stays for conditions such chronic obstructive pulmonary disorder, chest pain, and pediatric asthma, she says.

Hale adds that Medicaid agencies are very straightforward in what they will pay for and often deny payment for situations where social issues are involved, and a pediatric patient is at risk. "Case manager should document any social issues but it may have no bearing on the denial. I've seen some incredibly sad tales in medical records documentation when the admission still was turned down," she says.

Redman adds that when there are clinical issues that need to be addressed but the patient doesn't meet InterQual criteria, the physician contacts the Medicaid agency's physician advisor and presents additional information as to why the patient should be admitted.

"If we believe that patients need to be admitted because of a combination of clinical and social reasons, we initiate the peer-to-peer review," she says. ■

Keep on plugging on ICD-10

Delay is only temporary

The U.S. Department of Health and Human Services (HHS) has delayed the implementation of the ICD-10 procedure and diagnostic coding set, but that doesn't mean that hospitals can forget about preparing for the conversion to the new system, says **Deborah Hale**, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, a healthcare consulting firm based in Shawnee, OK. "If hospitals think they're off the hook and drop their preparations, they're going to have problems in the future. If hospitals haven't converted to the ICD-10 system by the time implementation takes place, they will have no way to bill for their services," she adds.

HHS announced in February that is was delaying the Oct. 1, 2013 implementation of ICD-10 because of concerns from the physician community about the administrative burden the conversion puts on them. The agency has says it will announce a new date for implementation some time in the future.

"Hospitals have already spent millions getting ready because HHS said there would be no delays and many large health systems are moving ahead as though the date is firm. I recommend that case managers continue to learn about the new system and how it's going to affect their daily work so they'll be ready for the inevitable conversion," Hale says.

Joanna Malcolm, RN, CCM, BSN, consulting manager, clinical advisory services for Pershing, Yoakley & Associates in Atlanta, says hospitals should take a breath and be glad they have a little more time, but keep on moving toward implementation, Malcolm says.

"I was on a team that worked with one client on assessment and it was amazing to me how it literally affected every part of the hospital. The complexity and the amount of work it takes to convert is tremendous," she says.

Because the coding for ICD-10 reflects a greater level of detail, coders will need more accurate and detailed information to assign the correct code to the procedure, Malcolm says. ICD-9 codes are used in all the reports that case management directors use every day, such as quality indicators and core measures compliance, Malcolm says. "Case management software has to be updated to accept the expanded fields

EXECUTIVE SUMMARY

The U. S. implementation of ICD-10 has been delayed but hospitals should continue to prepare for the eventual conversion.

- The ICD-10 code set has more fields than ICD-9 and requires a more detailed level of documentation.
- Implementation will affect every part of the hospital, including case management software which must be updated to accept the expanded fields.
- Case managers need to understand what the new coding set means and how it will affect their work.

and to interface with all of the other information technology that uses ICD-10 codes." In addition, keep in mind that insurance companies are going to need ICD-10 information to approve hospital stays and services, as well as post-acute services, she adds.

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

Care management cuts ED use for pain

Follow-up care is key to success

Before Kootenai Medical Center in Coeur d'Alene, ID, began its pain care management program, emergency department physicians were spending 36% of their work day seeing patients whose primary complaint was pain, excluding orthopedic patients and those experiencing chest pain. Now the physicians spend about 8% of their work day with pain patients, and emergency department visits for patients in the program have dropped by 77%.

"We started the program because we had a lot of patients visiting the emergency department complaining of pain. We know that giving them medication and turning them loose is not the answer. We determined that we needed to do a better job of follow up care, which in turn frees the emergency department physicians to concentrate on emergent patients," says **Bat Masterson**, RN, emergency department case management at the 246-bed acute care hospital. The medical center, located in rural northern Idaho, sees 50,000 patients a year in the emergency department.

When the program began, the majority of patients who came to the emergency department with pain complaints were not seeing a primary care physician for follow up. Now about 86% of patients are following up with a primary care physician.

The program aims to reduce repetitive patient visits for chronic pain or pain-related complaints in the emergency department by ensuring that patients receive appropriate and consistent pain treatment. Masterson led a collaborative effort with physicians, nurses, social workers, addiction specialists, and pain specialists serving on the team. The team reviewed the medical records and identified individuals who presented with vague pain complaints or chronic back and leg pain, and a high number of emergency department visits, based on Medicare criteria which defines excessive visits as three in a month or six in a year.

Case managers cover the emergency department 12 hours a day, seven days a week. "Besides approving admissions and assigning status, pain management is a big part of their duties," he says.

The case managers are alerted when patients with an excessive number of visits for pain come into the emergency department. The case managers meet the patients when they are in the emergency department and many times, they see the patient before the doctor does. They find out if the patient is seeing a primary care physician on a regular basis and work with the patient and the physician to develop a care plan.

"Many times, it takes as long as 30 minutes to sort out the situation. The case management interventions help the physicians because they don't have to spend so much time trying to get a good idea of what is going on with the patient," Masterson says.

A key to the program is helping patients learn how to navigate the healthcare system appropriately. Some of the patients are not connected with a medical home, in part because they are eligible for Medicaid and a lot of physicians don't take Medicaid patients. The emergency department case managers help those patients find a physician that will treat them. Others are addicts or drug abusers and are offered the opportunity to participate in a substance abuse program.

EXECUTIVE SUMMARY

A pain care management program at Kootenai Medical Center has resulted in a 77% decrease in emergency department visits by patients whose primary complaint was pain.

- Case managers are alerted when patients with a history of repetitive visits present to the emergency department.
- They work with the emergency department physicians on a treatment plan and help them identify a primary care physician and make an appointment for follow-up care.
- Patients receive non-narcotic pain relief whenever possible and may be referred to a physical therapist if appropriate.

"A lot of patients have multiple issues and simply fall out of the system. It's more convenient to come back to the emergency department, particularly if they don't have insurance. Having advocacy within the facility is very important in helping them learn to manage their pain appropriately," he says.

The program calls for non-narcotic pain relief whenever possible and as a standard of care for patients with headaches. "Our basic philosophy is not to add more narcotics. We make sure that patients who are truly experiencing chronic pain get appropriate care and are managed appropriately. Patients with true chronic pain need the skills to deal with it," he says.

The case managers perform functional assessments and educate patients about ergonomics. They refer patients to physical therapists as appropriate/needed. "We help them understand that the answer to their chronic pain is not more narcotics," he says.

The team works closely with primary care physicians in the community to coordinate care for the patients. The community physicians are invited to the team's bi-monthly interdisciplinary meetings where each patient in the program is discussed. "This strategy has been beneficial for the primary care providers as well as shown by the increased number of referrals to the pain care management program by the primary care providers themselves," he says.

The hospital communicates with other hospitals in a 150-mile radius to alert staff when patients are enrolled in the pain care management program. "We don't want our patients to go from emergency department to emergency department in search of drugs," he says. ■

Re-engineered discharge cuts readmissions

Components include education, follow-up

Before North Broward Medical Center in Deerfield Beach, FL, re-engineered its discharge process two years ago, 29% of patients were being readmitted within 30 days. Now, the figure has dropped to 15%.

When the hospital began the initiative in the wake of the Centers for Medicare and Medicaid Services (CMS) proposal to penalize hospitals with excessive discharges, a multidisciplinary team examined data from CMS and from the Agency for Health Care Administration, which administers the Florida Medicaid program, looking specifically for patients with congestive heart failure, pneumonia, and myocardial infarctions, says **Gavin Malcolm**, LCSW, regional manager for case management for the medical center.

The team examined the records of patients admitted within 30 days and interviewed them to determine the reasons for the readmissions. Their findings were somewhat of a surprise. The team expected that there would be a difference in readmission rates by payer but determined that readmission rates for patients with Medicare, Medicaid, commercial insurance, and self-pay patients were virtually the same, he says.

The expectation was that the readmissions were caused by a major systems issue or another major problem but it boiled down to the fact that patients didn't understand their disease, the importance of follow-up visits to their primary care physician and why they should follow their treatment plan, Malcolm says. "The review was definitely eye opening. We determined that you can give patients medication but if they don't understand why they need to take it, they aren't likely to continue to take it when they start feeling better," he says.

In one instance, one readmitted heart failure patient reported that he couldn't weigh himself because he didn't have a scale at home. "That seems basic to the heart failure treatment plan but nobody asked him the question," he says.

The key to a successful readmissions reduction

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EXECUTIVE SUMMARY

By re-engineering its discharge process, North Broward Medical Center in Deerfield Beach, FL, reduced the number of readmissions within 30 days from 29% to 15%.

- A multidisciplinary team determined that many patients were readmitted because they didn't understand their disease or why they should follow their treatment plan.
- All clinicians were taught the teach-back method and now encourage patients to ask questions about their condition and treatment plan.
- The night shift nurses go over the discharge plan the night before patients are discharged and make sure the patients have everything they need, such as food and support, at home.
- Case managers and pharmacists call patients after discharge to ensure they have a follow-up appointment and answer questions about their treatment plan.

CASE MANAGEMENT INSIDER
Case manager to case manager

Implementation and coordination of daily case management process in action

By **Toni Cesta**, PhD, RN, FAAN
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[Editor's note: Last month in Case Management Insider*, we started our discussion on the case management process. We reviewed the first two steps in the process which were "selection and screening" and "patient assessment and diagnosis." In this month's edition we will continue to review the steps that case manager's use in their daily work to achieve positive outcomes for their patients and their organizations.]*

Like any process used by a healthcare professional, the steps of the case management process are not always linear. At times, they might zig zag and alter course. However, there are steps to be completed, even if they are not always in perfect sequence.

In last month's step two, "patient assessment and diagnosis," we looked at a sample case management assessment form. This form should be completed on the day of admission to the hospital so that the next steps in the process can be completed. The information collected in Step 2 helps the case manager understand exactly what the potential discharge destination will be and sets the course for the hospital stay as well.

Once the patient has been identified and the initial assessment has been completed, the case manager must begin step 3, which is to create a case management plan of care.

The plan should be based on the needs identified during the assessment process. The assessment includes a review of the current and prior medical records, including the emergency department record if available. It also includes an interview of the patient and family, or family caregiver. Finally, the case manager should speak with the attending physician of record to gather as much relevant information as possible, including what event precipitated admission to the hospital.

In collaboration with the healthcare team, the case manager develops an interdisciplinary plan of care that includes expected outcomes of care, day-to-day interventions, an interdisciplinary teaching plan, and a discharge plan. The case manager may use a pre-existing national guideline or a hospital-specific guideline as the foundation for the plan of care. In some instances, multiple diagnoses might be involved, and an integration of more than one plan might be necessary. The plan should allow for the most cost-effective interventions possible, while optimizing each day that the patient is in the hospital. In addition, the plan must be developed with the patient, family, and/or family caregiver in mind as well. Once the plan is developed, it should be discussed with the entire interdisciplinary care team and modified if necessary. Consideration should be taken to include all members and the interdisciplinary outcomes of care.

Finally, the plan should be discussed with the patient and family so that the care progression and length of stay are clear to them and leave no room for surprise. This time is the case manager's opportunity to review the anticipated discharge destination as well. The clinical needs of the patient must be coordinated and facilitated with the interdisciplinary care team and the ancillary departments. This step will help to ensure that care is progressing appropriately. Each day must be optimized so that the patient meets an acute level of care. This optimization ensures an appropriate stay as well as appropriate level of reimbursement.

A plan also must be created to address any psychosocial and/or financial issues that might have been identified. The plan may include a referral to social work, psychiatry, clergy, or palliative care, among others. It also might include a referral to a financial counselor or other appropriate person if a Medicaid application is needed. Other financial needs might include financial assistance in obtaining medications or other needed resources. Depending on the resources available in your hospital, you might be able to obtain some, or all, of the needed resources internally. ■

Step 4: Link patients to needed services

In terms of the daily case management process, once a patient's case management plan has been developed and reviewed with the interdisciplinary care team, a case manager can begin step 4: Reach out to the other departments or disciplines with whom the patient might need to be interfaced. This step also is known as coordination and facilitation of care.

For example, the patient might need to be referred to the social work department. Depending on the role of the social worker in a particular hospital, this referral might be for nursing home placement, psychosocial counseling, or crisis intervention. The sooner the assessment is performed after admission, the sooner the referral process can take place.

The same logic would apply to a referral for home care services. Making the home care referral as soon as possible after admission will reduce the potential for a delay in obtaining those needing home care services that ultimately can mean an increase in the length of stay.

Case managers play an important role in ensuring that care is received as appropriate and in a timely manner. This happens through proactive coordination of the processes and then the actual facilitation of those processes. For example, if a patient needs to have an MRI to make a definitive diagnosis, and there has been a delay in getting that MRI done, the case manager would be responsible for determining the cause of the delay and correcting it. This component of the case manager's role impacts quality of care, cost, and length of stay. To perform this step well, the case manager must have worked with the team on the development of the plan of care and goals of care.

If the patient needs a referral for financial assistance, this step also should be done as soon as possible. If it is anticipated that continuing care services are going to be needed in the community, the sooner a Medicaid application is initiated, the less delay there will be as the patient progresses toward discharge.

Other types of referrals might include pain management or palliative care. Palliative care should always be a consideration for case managers when the patient has a chronic condition, issues with pain management, or is at end of life.

In some circumstances the case manager might identify a needed consult or referral, but he or she might need to obtain a doctor's order for the consult or referral. If this process is the one used in your hospital, then you should speak to the attending of record, provide your rationale for the consultant or referral, and ask that it be ordered. In other instances, you might not need to obtain a doctor's order, but you might be able to facilitate the process independently. ■

Step 5: Implement, coordinate patient needs

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

The case manager must ensure that the patient's clinical needs are coordinated and facilitated throughout the hospital stay with preparation for the post-acute setting as well.

This step 5 in the daily case management process is dependent on the development of an interdisciplinary plan of care with achievable care goals for each hospital day. Among the interventions that might require coordination and/or facilitation are included tests, treatments, procedures, consults, and education. In step 5, we listed some of the types of consults or referrals a case manager always should be thinking about.

In addition, the case manager must ensure that diagnostic interventions and treatment interventions are occurring in a timely and appropriate order. The case manager plays a critical role in determining the full set of interventions necessary and then choreographing them so that there is no

out-of-sequencing and no delays. It is during this process that the case manager would be evaluating for redundant or duplicate ordering that might drive up the cost of care without adding any quality to the process. This problem is not uncommon in radiology testing and laboratory testing. Not only do redundant tests increase cost, but they also increase the length of stay and expose the patient to interventions that they might not need.

Any clear delays should be logged in as avoidable delays and should be corrected at the point of care whenever possible. Look at these delays in real time but also in the aggregate so that patterns and trends can be corrected over time.

The plan of care should be shared with the patient and family so that they understand the potential services that the patient may receive while in the hospital and following discharge to the community. Case managers should clearly identify their role to the patient and family, as well as the expected outcomes of care for the hospitalization. Engaging the patient, family, or family caregiver is an important component of the coordination-of-care process. The more information you provide to the patient and family, the greater the likelihood that they will be able to participate in the care processes and discharge planning processes.

This step is also an important way to improve patient satisfaction. One of the bigger patient complaint areas is lack of communication. Remember that the patient and family might need to hear information more than one time due to pain, anxiety, sedation, etc. By communicating with the patient and family from the beginning of the hospital stay and daily throughout the stay, the case manager can reduce the likelihood of missed or misunderstood information.

Implementation of the plan of care requires good verbal as well as written communication. Verbal exchanges can take place on interdisciplinary care rounds and informally throughout the day as needed. Communication should include both the giving as well as receiving of information. In addition, information can be shared in the medical record as another means of communication, and as legal documentation of the plan of care and appropriate interventions.

The sequencing of patient care processes falls under the role of patient flow and is one of the most important functions that a case manager performs. By coordinating care, the case manager ensures several items. These include:

- proper use of resources including reduction of duplication or redundancy;
- management of the length of stay;
- decreased likelihood of receiving a denial;
- improved patient satisfaction. ■

Step 6: Monitoring of care processes

By **Toni Cesta**, PhD, RN, FAAN
Senior Vice President
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As with the other process steps in the daily case management process, monitoring is a step that goes on continuously and repeatedly.

Monitoring, which is step 6, involves the continuous overseeing of the patient's movement toward, and/or achievement of the goals of care. You might need to adjust the plan as the patient's condition progresses toward discharge. The case manager must assess and reassess the patient on a daily basis to determine progress and whether changes to the plan are needed.

Assessment takes place using a variety of strategies. Included are daily patient care rounds. Rounding is a great way to engage with the other members of the interdisciplinary care team and work together to determine the patient's progress toward the achievement of the goals of care.

It is also during rounds that a discussion can take place if a change in the plan is needed. By actively discussing the goals of care, the team can keep an eye on the expected length of stay and adjust it as needed. This step might mean shortening the expected length of stay if the patient is progressing more quickly than anticipated, or lengthening it if the patient is progressing more slowly.

Other assessment tools include a daily review of the medical record, particularly looking at lab and radiology results, and nursing and physician documentation. Ongoing monitoring is helpful in length of stay management, but this information also can be used to inform the clinical review provided to the third party payer, if necessary. This information is also critical to the determination of the transitional and discharge plans. While some case managers might

think that they cannot provide the time needed for ongoing assessments, clearly this information ultimately can streamline many of the other roles and functions that the case manager must perform. ■

Final steps: Advocacy, evaluation and follow-up

By **Toni Cesta**, PhD, RN, FAAN
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Lutheran Medical Center
Brooklyn, NY

Advocacy is more than a step in the case management process. As discussed in a prior issue of *Case Management Insider*, this element is applied to all the roles and functions that a case manager performs. Therefore the case managers should be thinking about their role as patient advocate at all times.

Advocacy occurs on many levels. The case manager might need to ensure that tests, treatments, and procedures are occurring in a timely fashion (patient flow). The case manager might need to advocate for a continued hospital stay with a third party payer due to the patient's speed of care progression (utilization/denial management). The case manager might need to advocate for continuing care services in the community (discharge planning). The case manager might have to advocate for a specific consultation, such as palliative care, for example.

Dilemmas can arise when the case manager has to advocate for interventions that might increase the length of stay or the cost of care. Whenever these kinds of issues arise, the case manager always should place the patient in the forefront of the solution and consider cost secondary.

The case manager's role as a patient advocate cannot be overestimated. It is a critical component of the work of the case management and of the case management process. Each time a case manager makes a decision on behalf of a patient or family member, their role as patient advocate should be foremost in their mind.

Evaluation and follow-up

The case manager must continuously evaluate the patient's progress toward expected outcomes. Evaluation is based on the assessment done as described in step six. Evaluation, which is step 8, involves the critical analysis of the information collected during the assessment and reassessment processes. It requires that a decision be made as to the next steps and/or change in the plan of care.

Evaluation cannot be done in isolation, but rather it should be done collectively with the entire interdisciplinary care team. Eventually the patient will transition to the next level of care. The case manager has a responsibility to ensure that the progression is timely and appropriate. If the patient is discharged to home, the case manager should follow up to ensure that the planned services are received and that the patient's needs are being met.

Many case management departments have begun calling patients after discharge to evaluate whether continuing care services have been activated in the community. This follow-up call can be done by one of the professional staff members or a clerical staff member. If clerical staff members are used, they should have a carefully worded script to use and should have clear criteria as to when to escalate an issue if necessary. Calling patients can be labor intensive; sharing the work between clerical and professional staff can be one way to address this problem.

Consider post discharge follow-up in the context of readmission reduction, coordination of care across the continuum, patient satisfaction, and reduction of inappropriate emergency department visits and/or admissions.

In this issue we have discussed the importance of using the case management process as a structure for organizing the work of case managers in their daily practice. While the process is not linear, it does provide a context with which to organize work that can sometimes be variable and unpredictable. In the day-to-day life of a hospital case manager, the work will vary according to the needs of the patient on a given day and at a given moment. Because of this challenge, having a structured framework can be a valuable tool, as the case manager works toward achieving specific outcomes on behalf of the patient, the family, and the organization they work for. ■

Continued from p. 70

program is to make sure that everyone who comes in contact with the patient owns the educational process and understands that it's not just the job of case management and social work, Malcolm says. "Education is an ongoing process and not just something that happens when the patient is at the door, ready to leave," he adds.

Under the new process, the night shift nurses are involved in the discharge plan. The discharge paperwork is drawn up ahead of time and reviewed by the night nurse so that any discrepancies or medication reconciliation issues are picked up by the nurse and not discovered when the patient is ready to leave, he says. The night shift nurses go over the discharge plans with patients who are being discharged and ask questions to determine their ability to manage at home. For instance, they ask if the patient has food at home. "Obviously, patients aren't going to leave the hospital and go shopping for groceries. If they don't have food, we contact an organization that provides home delivered meals so the patients will have food for a few days," he says.

Another key to the success of the plan is to ask patients questions and encourage them to ask questions, Malcolm says. "The idea is to communicate to patients that it's important to us that they ask questions. The older generation tends to feel that they're being a burden when they ask questions and we want to constantly reinforce that we want them to ask any questions they have so they can know as much as possible when they go home," he says. The entire staff, including the non-clinical staff, such as social workers and dieticians, they reinforce the need for patients to ask questions when they make rounds and invite them to ask questions.

In addition to writing the discharge orders, physicians reconcile medication, and if the patients are getting new medication, making sure they understand not to take their old medications.

The nurse managers and the nurses on the floor call patients two days after discharge to make sure that all the patients' questions are answered, and to find out if there are other issues, such as home health workers not showing up. They make sure the patients have a number to call with questions and concerns, and they have their medication and understand how to take it.

The hospital pharmacists also make post-discharge calls to patients being discharged with four or more medications. They review the medication again and answer questions. If patients have been prescribed a new medication, the pharmacists make sure they have it. In most cases, the hospital pharmacy brings the medications to the patient's room before discharge, giving the patient an opportunity to ask questions.

The hospital has begun having an experienced nurse case manager make a home visit to follow up on patients who are at high risk for readmission. "We see this job as an important aspect of the total program and are transitioning the case manager to focus entirely on patients in the community," he says.

The case manager visits patients in assisted living centers as well as individual homes. "Our data showed that half of the readmitted patients came from assisted living centers. When we began looking into the situation, we found that assisted living facilities are not as supportive as many people assume," Malcolm says.

For instance, if residents in an assisted living center don't feel like going to the dining room for dinner, they often don't ask to have their meals delivered because they don't want to be a burden. "We found that in some cases, preventing a readmission was as simple as having someone deliver food to their rooms or making sure they had easy-to-prepare food in their rooms," he says.

SOURCE

For more information, contact:

• **Gavin Malcolm**, LCSW, Regional Manager for Case Management, North Broward Medical Center, Deerfield Beach, FL. Email: Gmalcolm@browardhealth.org. ■

Centralized process facilitates transfers

RNs get information needed for clinical decisions

By centralizing the patient transfer process, Baylor Health Care System, with headquarters in Dallas, has made it easier for patient to transfer from one hospital to another and facilitates communication between clinicians.

"The role of the transfer center is to facilitate the entire transfer process and obtain adequate clinical information for the Baylor hospitals to make an informed decision about the patient's needs," says **Elisa Ayers**, LMSW, CCM, director of care coordination support at Baylor Health Care System's Patient Transfer Center.

Before the health system opened the Patient Transfer Center in January 2009, community hospitals complained that it was difficult to get patients

EXECUTIVE SUMMARY

Baylor Health Care System's Patient Transfer Centers gives community hospitals a central number to call when they want to transfer patients into the Baylor system.

- RNs staff the center and obtain clinical information from the sending hospital.
- They make sure beds, and an admitting or consulting physician, are available.
- Process has increased satisfaction among hospitals, sending and receiving physicians.

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into the Baylor Health Care System because they had to call hospitals one at a time to find out if there were available beds. "We felt like we were losing business by making the process cumbersome and decided to set up one central process so community hospitals could more easily transfer their patients into Baylor hospitals," Ayers says.

The center is open 24-hours a day, seven days a week and has an all RN-staff, many of whom have been in nursing for 20 years or more. "This is a good opportunity for nurses who are looking for another way to use their clinical knowledge. The more seasoned nurses have the clinical knowledge and experience to decipher patient needs and understand what information is needed so informed clinical decisions can be made," Ayers says.

Initially, the staff was a mix of nurses and non-clinical staff who answered calls and obtained demographic information on the patients before transferring them to a nurse. "After about a year, we determined that this was not an effective process. The callers often began by rattling off clinical information that the non-clinical staff had difficulty understanding or prioritizing," she says.

During Phase 1, the center focused on inpatient to inpatient transfers. In Phase 2, which began in December 2011, the center began facilitating transfers from emergency department to emergency department. "Emergency department to emergency department transfers involves complying with the Emergency Medical Treatment and Labor Act (EMTALA) and the Texas Transfer Law requirements. There are some time constraints and we had to ensure we were good at our core processes before beginning the emergency department transfers," she says.

When hospital representatives call the center, they choose between three prompts: inpatient to inpatient transfer, emergency department to emergency department transfer, and physicians returning a call. The calls are prioritized according to which option is chosen. All phone calls are recorded.

For inpatient-to-inpatient transfers, the nurses start the call by obtaining patient demographics and the reason for the transfer. Then they ask if there is a preference of hospitals or physicians to follow the patients after transfer.

The nurse calls the hospital of choice and confirms there is a bed available and secures an admitting or consulting physician. Then the physician from the sending hospital talks to the physician in the receiving hospital. Once the physician and bed are secured, the transfer center nurse facilitates an RN-to-RN report between the sending and receiving nurses assigned to patients.

If the caller doesn't indicate a preference for a Baylor hospital or physician, the nurse selects a hospital based on location and service line, then calls to find out bed availability and talks to the on call physician for the specialty the patient needs. The transfer center uses the same process when patients are transferred from one Baylor hospital to another Baylor Hospital. About 75% of the transfers are external community transfers and 25% are transfers within the Baylor system.

Emergency department to emergency department transfers get top priority with a goal of turning around the transfer in 30 minutes. When the initial call comes in the nurse calls the receiving hospital to make sure there is bed capacity, facilitates the communication of clinical information and gets approval for the transfer.

All hospitals in the Baylor system share a bed tracking platform which allows the Transfer Center nurses to quickly assess bed capacity across the system. The transfer center uses data from the transfer software to generate reports for the hospitals showing the number of transfer requests, turnaround time from the time the call is initiated until the patient is placed, and information about patient diagnoses.

"To date, the Patient Transfer Center has placed more than 7,000 patients from the Dallas/Ft.Worth/Metroplex into the Baylor Health Care System. The centralization of this service has provided ease of access in transferring patients into the Baylor Health Care System, and has increased satisfaction among sending facilities and both referring and receiving doctors," Ayers says.

SOURCE

For more information contact:

• **Elisa Ayers**, LMSW, CCM, Director of Care Coordination Support at Baylor Healthcare System's Patient Transfer Center, Dallas. Email: ElisaA@BaylorHealth.edu. ■

Provide education on new access role

Invite others to observe staff

Many hospital associates believe that registration staff simply sit at their desk and greet patients, reports **Barbara Blum**, director of access, admitting, and registration at MedStar Health in Columbia, MD. "They have no idea what the registration staff's responsibilities include," Blum says.

Other departments might not realize that registration is a big part of the hospital's revenue cycle, for example, or that staff work with more than 100 insurance plans. "A goal is to verify upfront that the insurance is active. This allows a clean bill," says Blum. "Registration is a big part of upfront collections. If not collected upfront, it can result in bad debt."

Staff members in other hospital areas don't acknowledge the work of patient access because it's not understood, says Blum, but they are quick to blame access staff for mistakes they didn't make. "If there are any problems — incorrect labeling, an incorrect name in other systems, or delays in patient care — the assumption it is a registration error," says Blum. "This results in poor employee satisfaction and morale."

Blum says staff in other areas might offer to help when the registration system goes down with the attitude, "What could be so hard? Your staff are just clerks." To this, Blum responds, "It is not clerical data entry. You would need knowledge of insurance and the registration system."

Give presentations

Blum recommends giving a short presentation at a monthly manager's meeting on one of these topics:

- data captured on upfront copay collection for self-pay patients;
- your department's progress toward a goal of completing a registration within a certain number of minutes;
- the number of patients registered in an hour;
- claims denials due to lack of authorizations.

Blum suggests inviting managers to spend some time in the emergency department or outpatient registration areas. "In some areas, access sees over 100 patients in an eight-hour period," she says. "They will see that we are still smiling, collecting copays, verifying insurance, and identifying patients."

Inform others that you deal with every aspect of the hospital system, from data entry to diagnosis codes to complex financial problems, advises **April C. Robinson**, MBA, MHA, patient access manager at Palmetto Health Richland in Columbia, SC. "We are the first department that meets the patients upon their arrival at our facilities," she says. "We are also the first and last link in the revenue cycle chain for the hospital system."

Robinson suggests creating an interdepartmental team with leaders and staff members from nursing, the medical staff, patient access, pre-registration, patient billing, environmental services, and any department that is a part of patient care.

"This team should be tasked with the goal of learning about the job functions of each department," she says. "Everyone can learn how to fully utilize all talents, to provide the ultimate patient care experience."

SOURCES

To obtain more information on educating members of other departments on the role of patient access, contact the following persons:

- **Barbara Blum**, Director of Access/Admitting/Registration, MedStar Health, Columbia, MD. Phone: (410) 554-2204. Fax: (410) 554-2910. Email: Barbara.Blum@MedStar.net.
- **April C. Robinson**, MBA, MHA, Patient Access Manager, Palmetto Health Richland, Columbia, SC. Phone: (803) 434-5140. Fax: (803) 434-1481. Email: april.robinson@palmettohealth.org. ■

New access technology? A golden opportunity

Open up a dialogue

If your hospital is switching to an electronic medical record (EMR), this change is an excellent opportunity to start a much-needed dialogue with clinical areas.

"It opens up a whole new way of looking at things. You have the chance to throw out old traditions that aren't working and resolve some important issues," says **Barbara Snodgrass**, patient access manager at Mount Hood Medical

Center in Gresham, OR.

All of Mount Hood's departments are meeting to discuss the implementation of an EMR. "You need a lot of education between the departments, including access, so everyone understands how this new software is going to work," she says. "You don't want the patient to pay the price for a lack of communication."

For example, clinical staff members specified at exactly what point tracking boards are updated to show the patient is ready for discharge, and patient safety issues were discussed regarding clinical staff printing out their own patient labels for lab draws or wristbands, instead of waiting for patient access staff to do so. Questions such as "Are there time constraints for the clinical staff to do this?" and "Do we need more patient access staff to accommodate the new changes?" were addressed.

"Small changes can have a big impact," says Snodgrass. "It is vital to re-establish roles and responsibilities so everyone can be on the same page." Decisions need to be made about whether nurses or registrars will enter appointments in the EMR, she adds, which brings up the question of whether additional training is needed for either area. "There may be something that patient access can do to help the nurse set up the orders so that the process is seamless for the patient," says Snodgrass. She suggests you take these steps:

- **Be clear about every step in a process.** "Talk everything through. At what point in the process is an order is going to be faxed and by whom?" advises Snodgrass. "Don't make assumptions on either side."
- **Have joint meetings when rolling out a new process or technology.** During the planning process for opening a new children's hospital, Snodgrass gave input on customer service from a patient access standpoint. "One issue that came up was how much space is needed for an area where an upset patient can meet with a patient advocate," she says.
- **Address technology glitches.** Software problems can cause tension between clinical areas and access, as when a patient's surgery is scheduled on one system but the pre-surgery blood work is entered into a different system.

"There may be duplicate accounts because the software isn't interfacing well," says Snodgrass. "That sets you up for a lot of blame going back and forth — something clinical and patient access staff don't want." ■

Verify insurance without costly delays

Make it simple for staff

Registrars at UK HealthCare in Lexington, KY, have had great success using a real-time insurance verification tool, reports **Courtney M. Higdon**, director of enterprise patient access services.

"Over the past year, we have distributed this tool to all locations where appointment scheduling and check-in or registration occurs," she says. "100% of our accounts have real-time eligibility checks performed as patients are registered."

The tool will better equip the patient access department for the future, according to Higdon. "Insurance plan coverage and accessibility will change dramatically over the coming years with the implementation of healthcare reform," she says.

The tool gives staff the ability to access the requirements of all payers, whereas previously they relied on individual payer web sites or failed to do verifications at all, she explains. "Additionally, this tool has improved our ability to know what the copay collections opportunity is for each patient as they arrive," says Higdon. "Previously we were able to measure our actual collections, but were not always certain what the full opportunity was." This change allows patient access leaders to measure the opportunity for collections, as opposed to just the actual collections.

Collections at the organization's two hospitals' admitting offices and EDs have increased more than 100% from 2010 to 2011 because of the tool and other initiatives aimed at improving upfront collections, she reports. Collections in these areas increased from $313,000 in 2010 to $663,000 in 2011. "We are expecting to see a positive impact on eligibility denials as a result of real-time insurance verification," adds Higdon.

The biggest challenge was educating more than 100 staff operating in a decentralized model who hadn't previously performed eligibility verification about what it is and why it is important, says Higdon. "We are planning to assess each area in the upcoming year to measure the adoption rate of this tool across the organization," she says. "As we find areas that have been slow to adopt the tool, we will work to support their training needs more aggressively."

SOURCE

For more information on insurance verification processes, contact:

• **Courtney M. Higdon**, Director, Enterprise Patient Access Services, UK HealthCare, Lexington, KY. Email: Courtney.Higdon@uky.edu.

Utilize access staff in multiple areas

Cross-training is required

At Palmetto Health Richland in Columbia, SC, the admissions department's career ladder program requires cross-training in four admissions areas, financial counseling, and patient accounts.

"This has provided us with a pool of patient access representatives who are competent in multiple admissions areas," reports **Ebony Seymour**, CHAM, patient access manager. Seymour estimates that it costs about $1,000 for an employee to complete the cross-training. "Although it may seem like a large sum of money, the benefits of being able to utilize the staff in other areas is worth the expense," Seymour says.

A minimum of 20 hours of cross-training is required in each admissions area and financial counseling, which allows patient access representatives to provide coverage to short-staffed admissions areas.

"The career ladder process has increased our ability to flex employees between areas when we have call-ins, disasters, and holidays," says Seymour. "For example, an employee from the third shift in the emergency department can open main admissions at 6 a.m. if there is a call-in."

Because admissions processes are standardized, it's easier for patient access leaders to use access staff in other areas, says Seymour. Regardless of the admissions area in Palmetto Health's two Columbia campuses, which are Palmetto Health Richland and Palmetto Health Baptist, the registration system, forms, and signature capture are the same.

"We have the ability to utilize the patient access representatives across campuses," says Seymour. "The only information that they need to be able to perform their job responsibilities in another area is an understanding of the patient flow."

SOURCE

For more information on cross-training patient access staff, contact:

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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. ■

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 healthcare 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

- Why ED case management is more important than ever
- How to work closely with hospitalists
- Ways you can cope with difficult patients
- Improving transitions across levels of care

CNE QUESTIONS

1. True or False: According to Deborah Hale, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, if a hospital gets patients from multiple states, the staff will have to deal with multiple Medicaid RACs, different rules and appeals processes.
   A. True
   B. False

2. The U. S. Department of Health and Human Services has delayed implementation of ICD-10 until what date?
   A. October 1, 2013.
   B. October 1, 2014.
   C. A date to be announced at an undisclosed time.
   D. Indefinitely.

3. When North Broward Medical Center in Deerfield Beach, FL, analyzed the records and interviewed patients readmitted for heart failure pneumonia, and myocardial infarctions, what was the main reason for the readmissions?
   A. They were being discharged prematurely.
   B. They didn't understand their disease, the importance of follow-up visits with their primary care physician, and why they should follow their treatment plan.
   C. They didn't have support at home to help them in the first few days after discharge.
   D. Their low healthcare literacy meant they couldn't read their discharge instructions.

4. What is the role of the nurses in the Baylor Health Care System's Transfer Center?
   A. Triage patients coming into the emergency department.
   B. Facilitate transfers to post-acute levels of care.
   C. Obtain information from transferring hospitals about the patient's clinical condition, reason for transfer, and make sure there is a bed available and an admitting/consulting physician at the receiving hospital.
   D. All of the above.