# HOSPITAL CASE MANAGEMENT

*The essential guide to hospital-based care planning*

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## Include all diagnoses, payers in readmission projects

*Reimbursement penalties are on the way*

If you haven't expanded your readmission reduction projects beyond heart failure, pneumonia, and acute myocardial infarction, your hospital may find itself with reduced reimbursement in the future, warns **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY, and partner and consultant in Dallas-based Case Management Concepts.

Beginning with discharges on October 1 of this year, the Centers for Medicare & Medicaid Services will begin penalizing hospitals by 1% of their total discharges if they are in the top tier of hospitals with 30-day readmissions for heart failure, pneumonia, and acute myocardial infarction (AMI).

Many hospitals have concentrated their readmission reduction efforts on heart failure because it's their highest-cost, highest-volume diagnosis, and the one that results in the most 30-day readmissions, but that's no longer enough, Cesta says.

"If hospitals keep focusing on reducing readmissions only for certain diagnoses, they are missing the boat. Readmission reduction needs to be a hospi-

## Stakes Rise on Hospital Readmissions

As the Centers for Medicare & Medicaid Services begins to cut reimbursement for hospitals that have more 30-day readmissions than their peers and has announced plans to expand the program beyond the initial three diagnoses, Medicaid agencies and commercial payers are looking at their own programs to penalize hospitals for readmissions. In this issue, we provide tips and resources to help you meet the increasing challenges of preventing readmissions. We'll show you when to extend the discharge plan beyond the hospital walls, how to identify and engage patient caregivers, and why you should look beyond the patient's illness in planning discharge. You'll learn about two different methods two hospitals used to successfully reduce their 30-day overall readmission rates. It's all in this issue of *Hospital Case Management*.

talwide program regardless of diagnoses. Hospitals should take the lessons they've learned from heart failure readmission reduction programs and apply them to diagnoses across the board," Cesta says.

In this year's Inpatient Prospective Payment System (IPPS) final rule, CMS reiterated its intention to add new diagnoses to the readmission reduction initiative beginning in fiscal 2015 but did not specify what diagnoses will be added. *(For details on the proposed rule, see related article on page 107.)* Chronic obstructive pulmonary disease, coronary artery bypass grafting, percutaneous transluminal coronary angioplasty (PTCA) and other vascular procedures are among those under consideration. "CMS can look back three years to compile statistics on which they base the readmissions reductions penalties. This means it's important come up with a plan to reduce readmissions now for all diagnoses," Cesta points out. Eventually, hospitals that are in the top tier of hospitals with 30-day readmissions in the diagnoses selected by CMS for the program will be penalized as much as 3% of all Medicare discharges.

Commercial payers and state Medicaid agencies are starting to look at penalizing hospitals for excess readmissions, Cesta says. "We don't know the details in the state programs, but they are likely to be very different from the Medicare program," Cesta says. New York State's Medicaid agency is including all diagnoses in its readmission reduction program, she adds.

**Linda Sallee**, MS, RN, CMAC, ACM, IQCI, director for Huron Healthcare with headquarters in Chicago, asserts that case managers should assess every patient in the hospital regardless of payer for the purposes of discharge planning at the time they are assessing them for admissions criteria and level of care. "I'm a firm believer that case managers conduct a discharge planning assessment within 24 hours after admission to identify patients who have

## EXECUTIVE SUMMARY

As the Centers for Medicare & Medicaid Services begins to penalize hospitals for excess readmissions and state Medicaid agencies and commercial payers are likely to follow suit, case managers should assess all patients for risk of readmission regardless of diagnosis or payer. Experts recommend that you:

- Consider home health services even if it's just one visit for medication reconciliation.
- Make sure patients receive the services they need in the community to follow their discharge plan and stay out of the hospital.
- Take the patient's family dynamics and living conditions into account when developing a discharge plan.
- Identify and engage the patient's caregivers early in the hospital stay and get them involved in the discharge plan.

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the highest potential for readmissions," she says. Then spend extra time developing the discharge plan and beefing up the education for patients who are at greatest risk for coming back, she adds.

Cesta recommends assessing every patient for home care, even if it's just one visit for medication reconciliation. "Hospitals tend to under-refer for home care, which in many cases is covered by insurance, Medicare, or Medicaid. This is a no-cost way to keep patients from coming back to the emergency department or being admitted," she says. *(For other ways to provide follow-up in the community, see related article on page 100.)*

Case managers do a good job of identifying the need for home health for obvious patients, but many patients could benefit from a home health visit for medication reconciliation, she says.

"As much as hospitals try to conduct medication reconciliation, things do fall through the cracks," she says. Even if you give patients a list of medications they are to take upon discharge, they may go home and take a medication that duplicates one they were taking before hospitalization and end up in the emergency room. Older patients are particularly likely to find the new versus old medication regimen confusing, she says.

**B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, consulting firm specializing in hospital case management, agrees that home visits go a long way toward making sure patients understand their medication regimen and the rest of the treatment plan and are following it.

"Post-discharge phone calls and referrals to specialty clinics are good ideas, but case managers have to work past the idea and look at the application, and how successful it's likely to be with each individual patient," Kizziar says.

When you call patients after discharge, they may not be totally honest about their medication regimen and their adherence to the treatment plan, she adds. Home visits are more effective because the nurse can look in the medicine cabinet and see three different blood pressure medications or notice that the patient doesn't have a scale and get them one, she says.

"Many hospitals don't want to get into the home care business, but they can partner with a home care agency to follow up with patients in the home environment," she says.

Some hospitals have clinics for specific conditions, such as heart failure, and ask patients to come in shortly after discharge, Kizziar says. "Patients do need follow-up visits, but it obligates patients to leave their home and come to the clinic and to find their own transportation. If this is the only post-acute intervention, providers don't know for sure if patients have filled their prescriptions, if they have a scale or what's in the refrigerators, and if patients can't obtain transportation, they won't show up," she says.

Once you've completed the assessment, start planning for when the patient is going home. When patients transition from one unit to the next, make sure that pertinent information is transmitted, Kizziar suggests. The staff in the intensive care unit may not be developing a discharge plan, but they are observing and gathering information about the family and the home situation that could impact the patient's transition to the next level of care, she says.

Find out about your patients' home situations and take that into account when developing a discharge plan. Determine what resources patients have in the community and at home, determine that patient's financial situation, and determine whether the caregiver can take care of the patient after discharge, Sallee suggests *(For more on basing a discharge plan on the patient's home situation, see related article on page 101.)*

Engage the caregivers as early in the process as possible and provide education continuously during the stay instead of cramming it into the last couple of days, Kizziar adds. *(For more about engaging caregivers, see related article on page 101.)* Make sure the education is provided in the languages that patients understand and at a level that they can comprehend.

It's useful to have the caregiver involved early on, particularly if the patient is very sick, because they can see the patient progress and it won't be as upsetting or overwhelming to them when the patient gets home, Sallee says.

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For guides and checklists for improving transitions, visit the United Hospital Fund's website: www.nextstepincare.com. ■

# Extend the discharge plan beyond hospital walls

*Make sure patient needs are met at home*

Instead of thinking of case management as a hospital model, start thinking about case management as a continuum model, which transcends where people receive care, advises **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY, and partner and consultant in Dallas-based Case Management Concepts.

Look beyond the hospital walls to ensure that patients receive the services they need in the community to stay out of the hospital, she adds. "Hospitals can do a great job of discharge planning, but when the patient gets into the community, breakdowns can occur if they aren't connected to services in the community."

When patients are at greatest risk for readmissions or a return to the emergency department, hospitals should try to pass the baton to a community case manager, usually a nurse who works for the health system and is embedded in a clinic or physician office, Cesta says.

"Even if patients get home care services, when those are complete, they have no one to help them navigate. At-risk patients need to have a long-term relationship with someone who can make sure the care they need doesn't fall through the cracks," she says.

Case managers should stress the importance of keeping doctor's appointments and go the extra mile to make sure that patients have a follow-up visit with a primary care physician or specialist shortly after discharge, says **Carol Levine**, director of the Families and Health Care Project for the United Hospital Fund, a non-profit health services research organization based in New York City.

Make sure that the physician's office understands that patients need to be seen quickly. Sometimes a representative of the hospital can have more of an impact on getting an early appointment than a patient or family member can, she adds.

Lutheran Medical Center has partnered with its clinics to hold open slots every week for patients being discharged from the hospital, Cesta says. "Otherwise, it might take a couple of months for them to get an appointment," she says. The case management department clerical staff makes appointments at private physician offices, alerting the staff that the patient is being discharged and needs to be seen within seven days.

As lengths of stay decrease and the flurry of forms that payers mandate be given to patients increases, patients are often overwhelmed with a lot of information in a short time, points out **Linda Sallee**, MS, RN, CMAC, ACM, IQCI, director for Huron Consulting, headquartered in Chicago. It helps if case managers focus on the most important things patients need to remember and create a printed form with the information. Include the name and phone number of the home health agency and/or other post-acute providers, the name and phone number of their primary care provider, and the date of the next doctor's appointment, Sallee recommends. Give patients an alternative to coming back to the hospital. Educate them to see the doctor if they aren't feeling well as opposed to waiting until their condition deteriorates.

When patients are readmitted, make sure somebody goes to the home after the discharge and completes an assessment, checking on the patient's medication, food supply, and whether they have what they need to manage their condition at home. "So many times, patients go back to what they were doing before. It's a vicious cycle, and the only way to stop it is to find out what is going on in the home," Sallee says.

Each hospital needs to determine the diagnoses that are frequently readmitted in their particular area, Sallee says. Look at resources in the community that can help patients manage their condition after discharge and stay out of the hospital and emergency department.

Make sure patients have transportation to see their doctor or go to the drugstore to fill their prescription. If you're in a rural area or the patient is a shut-in, consider using telemedicine to monitor the patient's progress, she says. If they have psychosocial needs, or need help with meals or paying for medication, refer them to a program in the community that can help.

A lot of hospitals have begun calling patients at home after discharge, but it's not always useful, Levine points out. When patients and family members are inundated with phone calls from nursing, physical therapy, case management, and insurance companies, it gets annoying.

"Patients don't see the point of the calls and feel it's an intrusion. There are too many people making the calls and nobody is really listening. It's important to follow up, but hospitals need to find a way to elicit useful information and not just check items off a list," she says. She advises hospital to think out who is making the follow-up calls, when and why, and what happens to the information.

Sallee suggests telling patients they're going to get a follow-up call from the hospital and explaining the reason. "If you prepare them up front for what the

calls are going to cover, and the person making the call has access to the discharge plan and asks about it, you'll get a better response," she says. ■

# Involve caregivers in discharge planning

*Communication is key to a successful discharge*

When providers bring the family caregiver into the discharge process early, there is a better chance that the caregiver will be prepared to care for the patient at home, says **Carol Levine**, director of the Families and Health Care Project for the United Hospital Fund, a non-profit health services research organization based in New York City.

Beginning in 2010, the United Hospital Fund organized a Learning Collaborative with 37 teams from New York City hospital and post-acute providers to improve transition processes by involving family caregivers. The collaborative was based on the Institute for Healthcare Improvement's Model for Improvement.

"We didn't set out to reduce readmissions, but we clearly saw that engaging the patient and family caregiver does make a difference in preventing problems at home," Levine says.

The first step in the process is to develop a systematic way of identifying the caregiver and including it in the chart so whoever is working with the patient knows who the caregiver is, Levine recommends. Keep in mind that caregivers aren't always the "next-of-kin" or the "contact person." Look for the person who helps the patient at home with activities of daily living, meals, and transportation to medical appointments.

"There typically are a number of people who spend time with patients in the hospital. Clinicians can't just assume that the person at the bedside is the family caregiver. Even if it's the spouse or the oldest daughter, that person might not be the person managing at home," she says.

Keep in mind that the caregiver may be the partner or child of a lesbian, gay, bisexual, or transgender patient. "Lesbian, gay, bisexual, and transgender patients and caregivers often fear, with good reason, that they will be treated disrespectfully by the staff. There should be a zero-tolerance policy against discrimination. Hospitals shouldn't make more problems when there is a willing person who wants to help," Levine says.

It's illegal to tell partners of patients that they aren't real family members, and hospitals cannot use the Health Insurance Portability and Accountability Act (HIPAA) as a way to withhold information from them, she says. "In fact, hospitals should not use HIPAA to withhold information from any family caregiver responsible for the patient's care," she says.

Good communication is the key to a successful discharge, Levine says. "When case managers start talking to family caregivers in an attentive way and engage them in the discharge planning process, they build relationships and often gain information they would not have known otherwise. This saves time and helps them create a successful discharge plan," Levine says.

Involve caregivers in discharge planning early on. "A lot of problems are in timing. Case managers may start planning discharge on the day of admission but they aren't telling family members until the day before," she says. Include caregivers in your medication reconciliation efforts rather than relying on the patient to tell you what medications they are taking at home. Keep in mind that people in the hospital don't feel well and may not remember what you are telling them, so include the caregiver in medication management education.

Involve the caregiver in the decisions about discharge. "It makes a huge difference if caregivers understand what home care really provides, and what they will need to do when the patient gets home. If they know what the impact will be on them, they can make a better choice," she says.

Make sure the person caring for the patient understands what his or her role will be when the patient is discharged and that he or she is willing to do what will be required. For instance, if the patient is going to need wound care, educate the caregiver in the process and make sure that he or she is able to handle it. When you do teach-back, make sure you're really finding out if the patient understands.

Slow down and start listening. Instead of looking at your interactions as teaching the family and patient, look at them as a way to learn the best way to teach them. "Not all patients speak English fluently. Some learn visually. When case managers understand where people are in their own understanding of the disease, it makes a huge difference," she says. ■

# Look beyond the illness to create discharge plan

*Take family dynamics into consideration*

Case managers are more likely to develop a discharge plan that works if they look beyond the reason for hospitalization and take into consideration

everything that has been going on in the patient's life, says **Jackie Birmingham**, RN, MSN, MS, vice president emeritus, clinical leadership at Curaspan Health Group, a Newton, MA, healthcare consulting firm.

In most cases, patient assessments are completed when the patient is admitted, and often information case managers need to develop a workable discharge plan is missing, she adds. "Case managers have so many responsibilities that they often don't have the time to get a good idea of the patient's living situation but they need to know about patients' home and family situation as well as their medical conditions," she says. When patients are admitted, they're very sick and may not give complete information. Case managers need to go back when they're more stable and start asking questions about their family and their living situation, she advises.

"There's no such thing as a complex patient. It's the complex family. Case managers need to know about family dynamics and the living situation," she says.

Find out how patients have been managing at home and get a baseline of their living situation before hospitalization. Ask how they get help with meals or activities of daily living, how they get to the doctor, and how their medical condition affects their life. Find out if patients live alone and if they have family to care for them. If they live on the second floor, find out how they were managing. "It doesn't have to be an inquisition. Just ask about their life situation and what it means to them as far as following a treatment plan is concerned," Birmingham says.

"It's almost become a cliché that discharge planning begins at admission, but many times case managers don't really follow through in terms of looking beyond the immediate, and taking what may happen in after a week or a month to bring patients back to the hospital," says **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, consulting firm specializing in hospital case management.

Patients aren't always compelled to read their discharge paperwork and educational materials. When case managers go over the discharge information with patients, they should make sure the patients understand the message but go further and determine if they know how to incorporate it into their daily lives, she says. Take the time to determine what you can do to help patients follow their treatment plan.

"One of the best ways to prevent readmissions is through providing information to patients and families that they can understand and incorporate into their daily life," Kizziar says.

"We need to evaluate how useful the information we are providing will be to the patient and the family. It's one thing to say they need to do something, but we need to determine if what we are suggesting can fit into the patient's lifestyle and culture," she says.

**Kathleen Miodonski**, RN, BSN, CMAC, manager for The Camden Group, a national healthcare consulting firm based in Los Angeles, adds that case managers need to form a partnership with patients and family members in order to have a successful discharge.

Find out how your patients make decisions. For instance, do they seek the advice of family members or friends? Listen carefully when they talk about their concerns about their condition and when they discuss their goals. "Sometimes the goals of the patient and family are not the same goals as the case manager or the healthcare team. In order to develop an effective discharge plan, case managers need to understand what the patient wants," she says.

When you are working with complex patients, it's important to facilitate a care conference and prepare the healthcare team for the conference, Miodonski says. "Often, multiple specialists are each telling the patient a piece of the treatment plan and discharge plan and nobody is putting the whole picture together. It's important to get the team together to review all the issues so everybody will have the same message," she adds.

During the conference, keep everybody focused on the target and continue to act as a patient advocate, she advises. Make sure that the treatment team presents options in terms that the patient can understand, she says. If the patient and family don't ask questions, ask on their behalf to help them get engaged.

Remember that unless patients have been declared incompetent, they have the right to self-determination. "Case managers need to keep in mind that while they want the best for the patient, they have to respect what the patient's wishes are," Miodonski says.

As patient advocate, the role of the case manager is to present all options and the consequences of each decision, she says. Help support patients and families in the decision-making process and try to understand why they choose the path they are taking, she says.

If patients are resisting a post-acute facility, it may help to have them talk with a representative from the facility. If families insist that they can care for the patient at home, get them involved in the patient's daily care, such as changing a bed with somebody lying in it. "Help them figure out what they have to do and when and they may see the enormity of care in the home," Miodonski says. Give patients and family members an alternative if the path they choose doesn't work.

When you talk to patients and family members, be sure to thoroughly document the conversation, Miodonski advises. "It's critical that case managers document their role in supporting the patient and family," she adds. ■

CASE MANAGEMENT INSIDER
Case manager to case manager

# The Role of Case Management in an Era of Healthcare Reform – Part 1

*Value of healthcare being redefined*

By **Toni Cesta**, PhD, RN, FAAN
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Healthcare reform has been discussed for many years, at the federal, state and local levels. While its parameters have been unclear until recently, they are now coming into focus. There is no doubt that the changes imposed by the Affordable Care Act and its value-based purchasing agenda will negatively impact reimbursement across the continuum of care. The Centers for Medicare & Medicaid services are moving away from being a passive payer to an active purchaser of value-based care products and services.

The value of healthcare is being redefined. Quality is defined as a composite of patient outcomes, safety and patient experiences. Payment is the cost to all purchasers of care. Value is then defined as:

| | |
|---|---|
| Value = | Quality |
| | Payment |

This transition from quantity to quality is a paradigm shift for healthcare providers. Initially hospitals submitted charges to insurers and were paid for services rendered, with few questions asked. In the mid-1980s, a shift occurred to the inpatient prospective payment system (IPPS). IPPS created a shift from payments based on charges to a system using diagnosis-related groups (DRGs) to determine a case rate payment. The IPPS system was used in an attempt to control healthcare expenditures by capping the amount a hospital would be reimbursed for certain types of patients classified into DRGs. Despite the development of this system, healthcare costs continued to climb. Managed care organizations began to grow as health care insurance purchasers sought to find lower-cost coverage for their employees. This shift toward managed care created a process to manage costs for the commercial patient population, but still left the Medicare and Medicaid patients in the old DRG system where costs were still climbing. Even with the introduction of MS-DRGs, costs did not decline.

The movement toward reforming the payment system in healthcare has taken on many forms. Some things are for sure now. See page 104 for an outline of the most significant changes that are affecting our business with their timeline.

## HealthCare Reform's Impact on the Business of Hospital Management

Some of the changes associated with healthcare reform are, and will continue, to have a profound impact on the business of hospitals. How they manage financially will be, in many ways, affected by how they manage clinically as measured by their quality outcome indicators. Among the most pressing issues that will have an impact are:

- National Coverage Determinations
- Local Coverage Determinations
- Readmissions

| Timeline of Significant Changes | |
|---|---|
| 2010 | Recovery Audit Contractors |
| 2010 | Acute Rehab Payment Reductions of .25%, Long Term Acute Care Hospitals Reductions of .5% Acute Behavioral Health Reductions of .25% |
| 2011 | Medicaid Hospital Acquired Conditions Penalties |
| 2011 | .1% Payment Reductions for In-Patient, Long Term Acute Care and Behavioral Health |
| 2012 | .1% Payment Reductions for In-Patient, Acute Rehab, Behavioral Health, and Skilled Nursing Facilities |
| 2012 | .1% Reimbursement Penalties for Higher than Expected Readmission Rates |
| 2012 | 1% Reimbursement Adjustment for Value Based Purchasing (VBP) Program for Data |
| 2013 | .3% Payment Reductions for In-Patient, Out-Patient, Acute Rehab, Long Term Acute Care, Skilled Nursing Facilities, and Behavioral Health |
| 2013 | Pay-for –Reporting Program for Long Term Acute Care, Acute Rehab, Hospice and Behavioral Health with a 2% Penalty for Non-Reporting |
| 2013 | Value Based Purchasing Expanded to Include More Conditions and Efficiency Measures; Payment Adjusted by 1.25% |
| 2014 | .2% Payment Reductions for In-Patient, Out-Patient, Acute Rehab, Long Term Acute Care, Skilled Nursing Facilities, and Behavioral Health |
| 2014 | Mandate for Individuals to Obtain Health Insurance |
| 2014 | Expanded Diagnoses Applied to Readmission Penalties and cap Increased to 3% |
| 2014 | Value Based Purchasing Program Payment Adjusted by 1.25% |
| 2014 | 1% Payment Reductions to Hospitals with Highest Percentile for Hospital Acquired Condition Rates |
| 2015 | .2% Payment Reduction for In-Patient, Out-Patient, Acute Rehab, Long Term acute Care, Skilled Nursing Facilities and behavioral Health |
| 2015 | Value Based Purchasing Program Adjusted by 1.75% |
| 2016 | .75% Payment Reductions for In-Patient, Out-Patient, Acute Rehab, Long Term Acute Care, Skilled Nursing Facilities and Behavioral Health |
| 2016 | Value Based Purchasing Payment Adjusted by 1.75% |
| 2017-18 | .75% Payment Reductions for In-Patient, Out-Patient, Acute Rehab, Long Term Acute Care, Skilled Nursing Facilities and Behavioral Health |

- Core Measures
- Hospital Acquired Conditions
- Reductions in Payment
- Meaningful Use
- HCAHPS Scores

## National Coverage Determinations

The National Coverage Determinations are a nationwide determination as to whether Medicare will pay for an item or service. Examples include carotid stents, bariatric surgery, and certain pacemakers. Case management departments would stay current on these lists and use them to determine appropriateness for admission.

The newest lists can be found at: https://www.cms.gov/medicare-coverage-database/indexes/nca-open-and-closed-index.aspx?bc=BAAAAAAAAAAA&#Closed.

## Local Coverage Determinations

The CMS definition of local coverage determinations is "for purposes of this section, the term 'local coverage determination' means a determination by a fiscal intermediary or a carrier under part a or part b, as applicable, respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis under such parts, in accordance with section 1862(a)(1)(A)"

Case management departments can use the following website to find their local coverage determinations for their area: https://www.cms-gov/DeterminationProcess/04_LCDs.asp.

## Readmissions

By now most healthcare organizations have implemented initiatives to reduce their Medicare readmissions within 30 days. However, you may be less familiar with the way in which CMS will be calculating your payment changes. *(See figure on p. 105 for an example the calculations used.)*

If you follow the table on page 105,

## Example Calculations

*The exemplar below provides the calculations used. Please note that the numbers are for instructional purposes only and do not reflect the calculations for any specific hospital.*

| | | Heart Attack | Heart Failure | Pneumonia |
|---|---|---|---|---|
| | # Pts | 217 | 601 | 353 |
| | # Readmissions | 49 | 175 | 69 |
| A | Hospital 30 Day Readmission Rate | 22.5% | 29.2% | 19.5% |
| B | U.S. 30 Day Readmission Rate | 19.8% | 24.8% | 18.4% |
| C | Excess Readmission Rate [A/B] | 1.14 | 1.18 | 1.06 |
| D | Excess Readmission Factor [C-1, if C is > 1] | 0.14 | 0.18 | 0.06 |
| E | Medicare In-Pt Operating Payments by Condition (MedPAR FFY 2010) | $1,536,500 | $2,443,400 | $1,208,600 |
| F | Estimated Excess Payment [D*E] | $209,500 | $433,500 | $72,300 |
| G | Total Estimated Excess payments [Sum of F] | $715,300 | 0.18 | 0.06 |
| H | Total Medicare Inpatient Operating Payments (MedPAR FFY 2010) | $55,387,900 | $2,443,400 | $1,208,600 |
| I | Uncapped Payment Adjustment Factor [G/H] | 1.29% | $433,500 | $72,300 |
| J | Capped Payment Adjustment Factor [I Capped at 1.0%] | 1.00% | 0.18 | 0.06 |
| K | Estimated FFY 2013 Medicare Inpatient Operating Payments | $57,416,300 | $2,443,400 | $1,208,600 |
| | Estimated Impact [J*K] | ($574,200) | $433,500 | $72,300 |

you can see how your ranking is calculated. By following lines A – C you can see how your hospital's rate is compared to the national rate, which gives you your hospital's "readmission rate."

On line D, if it is greater than 1.0, then your readmission factor is above the expected and an "estimated excess payment" is calculated (lines E- F).

Total estimated excess payments (line G) are the totals of the excess payments in line F.

The uncapped payment adjustment factor is G/H.

For this time period this is capped at 1%, so if your payment factor exceeds 1% it will be capped at 1% (lines I and J).

1% is then multiplied times the FFY 2012 Medicare inpatient operating payments for the hospital to give the final penalty amount (J * K).

You can check your ranking at the following website: www.hopitalcompare.gov

CMS considers readmissions as an "outcome" measure, so you should direct your search to the outcomes section of the website.

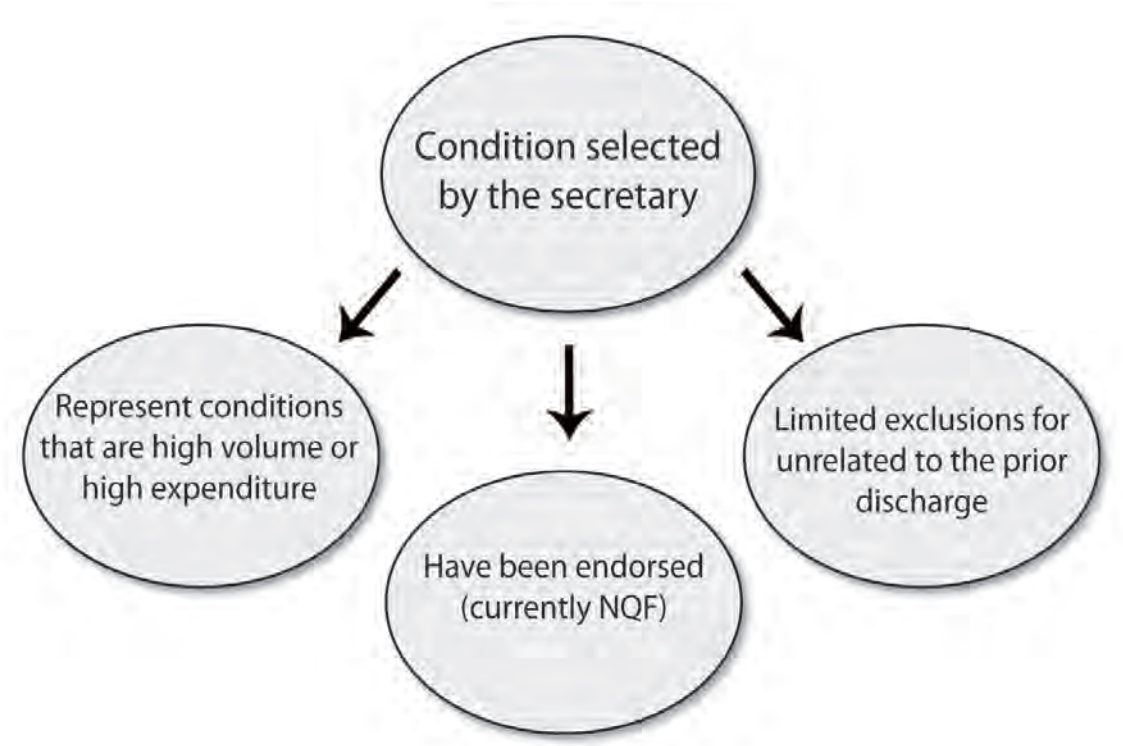
## Readmission Applicable Conditions

For Federal Fiscal Year (FFY) 2012 the three diagnoses used in the calculations are:

- 30 Day Risk-Standardized Health Failure (HF)
- 30 Day Risk Standardized Heart Attack (AMI)
- 30 Day Risk-Standardized Pneumonia (PN)

A hospital must have at least 25 discharges for each of the three measures to be included in this measure.

**How Are Applicable Conditions Determined?**




Excluded from Readmission Data
- Discharged Against Medical Advise (AMA)
- In-Hospital Deaths
- Not enrolled in Medicare for 30 Days Post-Discharge
- Transfers to Other Acute Care Facilities
- Same Day Discharges (AMI Only)

## Readmission Risk-Adjustment

Adjustments are made by CMS for case-mix differences based on the clinical status of the patient. Examples of these differences include:
- Demographic variables
- Co-Morbid diseases
- Indicators of patient frailty

Exclusions from risk-adjustment include:
- Admission source / discharge disposition
- Socioeconomic status (SES)

| Payment Penalty Cap – 3% |
|---|
| Expanded Set<br>FFY 2015<br><br>Under Consideration<br><br>• COPD<br>• CABG<br>• PTCA<br>• Other Vascular |

## Readmission Future Expansion

Next month we will continue our discussion of healthcare reform issues impacting case management! ■

# We want to hear from you!

Do you have a question for Toni Cesta about case management, or a topic you'd like her to discuss? Let us know and you may see the answer in a future issue of *Hospital Case Management*. Send your questions or suggestions to tcesta@lmcmc.com, and make sure to type *CM Insider* on the subject line.

# CMS continues emphasis on quality, efficiency

*Proposed IPPS strengthens VBP, IQR programs*

In the Inpatient Prospective Payment System (IPPS) proposed rule, the Centers for Medicare & Medicaid Services reiterates its intention to shift Medicare reimbursement from a system based on volume to one based on quality of care.

The proposed rule, issued in late April, strengthens the Hospital Inpatient Quality Reporting program and proposes new policies and measures for the Medicare Value-Based Purchasing Program, and adds two new conditions to the list of hospital-acquired conditions. In the proposed rule, CMS reiterated its intention to add new diagnoses to the readmission reduction program in fiscal 2015 but did not mention any specific conditions. There were no coding changes since the U.S. is transitioning between ICD-9 and ICD-10. CMS did not add any new MS-DRGs in the proposed rule.

CMS has announced a 2.3% market basket increase in reimbursement for hospitals that participate in the Inpatient Quality Reporting program, resulting in a net increase of 0.9% after the mandated coding and documentation adjustment.

The move by CMS to reward hospitals for providing efficient and high-quality care makes it more important than ever for case managers to make sure documentation is accurate and complete and clearly reflects patients' severity of illness and services provided, says **Susan Wallace**, MEd RHIA, CCS, CDIP, CCDS, director of compliance/inpatient consultant for Administrative Consultant Service, LLC, a healthcare consulting firm based in Shawnee, OK.

"Documentation can have a big impact on the hospital's payments under the Value-Based Purchasing initiative and the readmissions reduction program. Case managers should make sure the record clearly documents how sick patients are and appropriately identifies the reason they are admitted as inpatients," she says.

CMS emphasizes in the rule that it intends for hospitals to do a better job of managing care transitions, says **Evan Pollack**, MD, FACP, senior medical director of Medicare appeals for Executive Health Resources, a Newton Square, PA, healthcare consulting firm.

By identifying patients at risk for readmission, a hospital can be more efficient in its discharge planning, Pollack says. This means that case managers need to identify patients likely to be readmitted early in the stay and take steps to avoid the readmission, he adds. Services to help prevent readmissions can include home health, scheduling a follow-up appointment with a physician, and ensuring that prescribed medications were picked up. "CMS wants hospitals to target patients who are likely to be readmitted based on medical conditions as well as those requiring post-discharge care coordination and focus on providing services so that readmissions do not occur. In some cases, patients are so sick that it is inevitable that they are going to come back, and it may cost the hospital more to try to prevent a readmission than the penalty would be," he says.

The Inpatient Quality Reporting program, the Hospital Acquired Conditions program, and Value-Based Purchasing are all based on inpatient admissions, making it essential that patients are in the appropriate level of care at the appropriate time and that their admission status is clearly documented, Wallace adds.

Hospitals that have excessive readmissions within 30 days for patients with heart failure, pneumonia, and acute myocardial infarction will receive as much as a 1% reduction in reimbursement for all discharges beginning Oct. 1, 2012.

"All measures under the readmission reduction program are risk-adjusted based on the patient's condition. Case managers need to make sure that all conditions are documented so the hospital can get credit for them," Wallace says.

Making sure the physician documentation is clear and complete is essential, she adds. For instance, physicians should clarify the type of pneumonia a patient has. Aspiration pneumonia is not included in the readmission reduction program or the pneumonia mortality measure that is going to be part of Value-Based Purchasing.

Reimbursement based on the Value-Based Purchasing program also begins October 1. *(Look for more details on Value-Based Purchasing and how it affects case managers in the next issue of* Hospital Case Management.*)* Under the Value-Based

## EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services' proposed rule for the Inpatient Prospective Payment System strengthens ties between Medicare reimbursement and quality improvement.

- The proposed rule expands Hospital Inpatient Quality Reporting and Value-based Purchasing.
- Shift to payment for quality makes it essential for documentation to be accurate and complete.
- To ensure optimal reimbursement, hospitals must manage care transitions and take steps to avoid hospital-acquired conditions.

Purchasing program, hospitals' base DRG operating payment is reduced by 1% for each Medicare discharge. Hospitals have the opportunity to receive value-based incentives based on either how well the hospital performs on selected quality measures or how much the hospital's performance improves from its performance during a baseline period. Hospitals that perform well on quality measures or improve their performance on the measures would receive value-based incentive payments.

It's too late to impact payments under Value-Based Purchasing and the readmission reduction program for this year, Wallace points out. In fact, the baseline period for Value-Based Purchasing for fiscal 2014 is already over and the performance period starts either Oct. 1, 2012, or Jan. 1, 2013, depending on the measure. To ensure their hospitals' success in the future, case managers need to make sure that every patient receives evidence-based care and that the quality data submitted to CMS are accurate and timely, she adds.

In the proposed rule, CMS announced its intention to add two conditions to the list of hospital-acquired conditions for which hospitals will not be paid the higher MS-DRG rate if the complication is the sole reason for the higher payment. The conditions are: surgical-site infection following cardiac implantable electronic device and iatrogenic pneumothorax with venous catheterization.

To ensure that hospitals don't lose reimbursement, Pollack advocates using checklists and establishing team rounds that include physicians, case managers, nurses, and pharmacists who double check each other to make sure that nothing gets overlooked. "In addition to the other conditions on the list of hospital-acquired conditions, everybody on the team should understand how long the catheter or the central line has been in so as to avoid hospital-acquired infections," he says.

### SOURCE

For more information contact:

• **Susan Wallace**, MEd RHIA, CCS, CDIP, CCDS, Director of Compliance/ Inpatient Consultant, Administrative Consultant Service, LLC, Shawnee, OK. email:swallace@acsteam.net.
• **Evan Pollack**, MD, FACP, senior medical director of Medicare appeals for Executive Health Resources, Newton Square, PA. email:epollack@ehrdocs.com. ■


# CM program keeps high utilizers out of hospital

*Focus is on psychosocial and medical needs*

A care management program that concentrates on high-cost and high-utilizing patients with complex medical and psychosocial needs has reduced the overall readmission rate at the University of Michigan Hospitals and Health Centers to 17.4%, down from 20% when the initiative began.

A team of nurse care managers, social work care managers, and non-clinical patient care associates monitors the inpatient discharges and emergency department visits of all patients covered by Medicare, Medicaid Managed Care, and uninsured patients, which includes people covered by the county insurance program, according to **Brent Williams**, MD, MPH, medical director of complex care management at the University of Michigan Ann Arbor Medical Center.

The patient care associates call the less acute patients after discharge to make sure they understand their discharge instructions, have a follow-up appointment with their physician, and have filled their prescriptions. They screen for any potential problems and refer complicated or challenging patients to a care manager.

The care managers assess and provide brief follow-up for low-complexity patients at discharge and provide ongoing intensive care management for patients with complex medical and psychosocial needs. Each care manager typically provides intensive care management for about 25 to 35 patients at a time. The program concentrates on patients who are under 65 but are high utilizers of the emergency department and hospital, Williams says. Many of these patients have complex comorbidities and mental health or substance abuse issues. Many are homeless or have little social support.

Patients who qualify for the intensive care management program have impairments in at least three of the following domains: major psychiatric issues; behavior health issues, including personality disorders and substance abuse; complex medical conditions; diminished social support system; limited physical

## EXECUTIVE SUMMARY:

The University of Michigan Hospitals and Health Centers has reduced its overall readmission rate to 17.4% with a multi-pronged program that concentrates on patients who are under age 65 but high utilizers of healthcare services.
• Case managers provide high-intensity care coordination for about 25 patients at a time with complex medical and psychosocial needs.
• They visit them in the hospital and often accompany them to primary care visits.
• Non-clinical patient care associates make follow-up calls to less acute patients after a hospital discharge.

resources, including financial issues, poor living conditions, lack of transportation, and lack of healthcare coverage; and functional deficits.

When patients are identified for the program, the care manager initially contacts the patient by telephone and completes an assessment of the patient's condition and needs, then begins to fill in the gaps. In addition to medical issues, the assessment determines what the patients understand about their diseases, if they understand their medications and how and when to take them, if they have transportation to the pharmacy, and if they can afford their medication. The care managers find out if the patient has a primary care physician, if he or she has an appointment, and has transportation.

The care managers coordinate all of the patients' care needs, including getting them enrolled in home health if appropriate, coordinating care with any specialists, and facilitating transportation. If the patient is homeless, the care manager works with the case manager at the homeless shelter to get the patient a bed.

The care managers often accompany patients on visits to their primary care physician, and often can provide the physicians with information about the patients' social circumstances or financial issues that the physicians wouldn't otherwise know. "This creates a strong relationship between the care manager and the primary care physician. They meet with the patient and the three of them work together to develop a care management plan," he says.

Physicians traditionally base their treatment plan on the patient's disease and may be challenged by patients who have psychosocial needs. "The care managers can provide important education and help meet the patient's non-medical needs," he says.

Traditional disease management models assume that patients are motivated to change and have the resources available to them to help them manage their condition, Williams points out.

"This is not true for many patients who are in and out of the hospital frequently. What we do seems to make more difference than the traditional disease management programs," he says.

The care managers' computer program alerts them each day if patients in the program are in the hospital or have been to the emergency department. The care managers then visit the admitted patients in the hospital and work with the nurse care manager and the physician on the discharge plan. They follow up with patients who have been to the emergency department by telephone.

The hospital has organized twice-monthly meetings of care managers from throughout the Ann Arbor area. Participants include care managers from the University of Michigan Hospitals and Clinics, their counterparts at St. Joseph Mercy Health System, also headquartered in Ann Arbor, and care managers from the county health insurance plan, the local homeless shelter, a substance abuse program, and the county mental health department.

At the meetings, participants brainstorm on ways to coordinate care for vulnerable and under-served patients. "They get to know each other on a personal basis, and understand what the other participants in their organizations need as patients transition. This has facilitated a good working relationship and they often pick up the telephone or send an email to discuss problem cases," he says.

**SOURCE**

For more information contact:
• **Brent Williams**, MD, MPH, Medical Director of Complex Care Management, University of Michigan Ann Arbor Medical Center email: bwilliam@med.umich.edu. ■

# Initiative cuts readmission rate to 15%

*Improved communication was the key to success*

When Valley Baptist Medical Center in Brownsville, TX, began a project to reduce readmissions in the fall of 2009, the overall 30-day readmissions rate was 23.3%. Last quarter, the 30-day readmissions rate for all diagnoses was 15%, according to **Robin Jones**, RN, quality improvement coordinator at the 280-bed hospital.

After the initiative was begun, the hospital's patient satisfaction scores on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey improved, core measures improved,

## EXECUTIVE SUMMARY

Valley Baptist Medical Center has dropped its 30-day readmission rate to 15% by improving communication with patients and family members as well as post-acute providers.

- After a pilot project for heart failure patients, the hospital expanded the project to all admissions on medical units.
- The team adapted the Project RED (Re-Engineering Discharge) model to improve the discharge process.
- The hospital participates in communitywide meetings with post-acute providers organized by the TMF Health Quality Institute to improve transitions in care.

and medication errors and adverse drug events declined, Jones adds.

Working with the TMF Health Quality Institute, the Texas Medicare Quality Improvement Organization (QIO), the hospital conducted an analysis of readmissions to determine the top five DRGs and the root cause for the readmissions. Heart failure diagnoses made up three of the top five MS-DRGs that had the highest rates of readmission within 30 days. They included heart failure, heart failure with complications and comorbidities, and heart failure with major complications and comorbidities. The other diagnoses were kidney and urinary tract infections and pneumonia.

A multidisciplinary team determined that many of the reasons for readmission involved communication. Patients and caregivers often were not prepared for discharge or self-management. They didn't understand their medications, the need for follow-up care, or symptoms that could mean an exacerbation. Other causes included weak or fragmented discharge plans, inadequate follow-up care, and miscommunication or failure to communicate key information when patients transitioned to another level of care.

The analysis determined that the majority of patients being readmitted were those going home with no services and those who were discharged to skilled nursing facilities. *(For details on how post-acute providers were involved in the initiative, see related article on page 111.)*

The team researched readmission reductions models and determined that Project RED (Re-Engineered Discharge) would best meet their facility's needs. Project RED, developed by Boston University Medical Center's research team, involves patient-centered education, comprehensive discharge planning, and post-discharge follow up. *(For more information on Project RED, visit: http://www.bu.edu/fammed/projectred.)*

Because there were so many heart failure readmissions, the hospital conducted a pilot on the telemetry unit for heart failure patients and over the next 12 months expanded the initiative to include all patients on medical units, Jones says.

"Reducing readmissions is all about communication. Patients and family members need to understand their disease, their treatment plan, and what to do if signs and symptoms indicate an exacerbation. It's not enough just to tell them. We have to make sure they understand," she says.

At Valley Baptist Medical Center, patient education is continual during the stay, rather than being concentrated as the patients near discharge. Whenever anyone on the treatment team gives patients information, he or she uses the teach-back method to make sure the patients understand it. "We've done a lot of education on the teach-back method and on tailoring teaching to the patient's level of understanding. In the past, we took it for granted that the patients could understand the information we were giving them," she says. The team reviewed the discharge materials and made sure they were simple and could be understood by people with a third-grade reading level.

The hospital surveys all patients in the target population on the day of discharge, using a questionnaire developed by the TMF Health Quality Institute, to identify areas for improvement. "We believe that how patients feel about what we are doing is important. It doesn't matter what we are telling them. What counts is what they understand," she says.

For instance, in the beginning, when patients were asked to explain in their own words what they had learned, scores ranged from 67% to 75%. After the TMF Health Quality Institute conducted an in-service on the teach-back method, patient response increased to 90% or higher.

To ensure that patients have follow-up physician appointments, the nurses make appointments for them. After the hospital began making the appointments, the number of patients seeing their physicians after discharge doubled, Jones says.

As part of the discharge process, members of the readmission reduction team make a follow-up call to patients two to three days after discharge to ensure they understand their discharge plan and medication list.

Before discharge, nursing compares the medication list the patients brought in with them with what they were prescribed in the hospital and educate the patient and family members on which medications to continue taking and which to stop.

The discharge team makes sure the downstream provider has the medication list and other discharge information. Instead of giving it to the patients and telling them to take it with them, the team faxes or scans the information. Community physicians who admit to the hospital can access the patient record through a physician information exchange.

The hospital created a new emergency department case manager position and discharge coordinator in case management to review the electronic health record and identify the cause for emergency department utilization and readmissions. She also reviews the previous care plan, medications, and post-discharge services and makes follow-up calls to assess their appropriateness. "It's easy to assess a patient and send them home with the same services they were receiving before admission, but we need to recognize that sometimes those services were not working and that's why they came to the hospital in the first place,"

Jones says.

Sometimes patients are readmitted because they are too embarrassed to say they can't afford their medication so they simply do not get the prescriptions filled, she says. "If we know this we can ask the physician to prescribe something cheaper. If that's not possible, we can refer the patient to a federally qualified community health center or other available community resources," she adds.

Source
For more information, contact
• **Robin Jones**, RN, Quality Improvement Coordinator. Valley Baptist Medical Center, Brownsville, TX. email: robin.jones@valleybaptist.net. ■

# Hospital, post-acute providers collaborate on transitions

When an analysis of readmissions indicated that a significant number of patients being readmitted within 30 days had been discharged to a post-acute provider, TMF Health Quality Institute, the Texas Medicare Quality Improvement Organization (QIO) established regular meetings with hospitals in the community, including Valley Baptist Medical Center in Brownsville, TX, and downstream providers including skilled nursing facilities, long-term acute care facilities, home health agencies, dialysis units, hospice providers, and rehab hospitals in the Brownsville area.

"The purpose of these meetings is to break down silos of care and to brainstorm on ways we could facilitate communication and coordination of care at transition. We also want to help participating providers share accountability and understand that readmissions are a community problem," says **Robin Jones**, RN, quality improvement coordinator Valley Baptist Medical Center-Brownsville.

The meetings, called Regional Workgroup meetings, are held quarterly. Participants discuss barriers to successful transitions and brainstorm on how to improve communication and coordination of care at discharge. The team from the hospital collaborates with case management and other staff at the post-acute providers to make sure that they are getting the information they need.

The home health agencies reported that they were getting inconsistent discharge information or were getting it too late. As a result, the team worked with the hospital case managers quarterly to develop ways to ensure that the home health agencies received all the information they need in a timely manner. "When we followed up with the home health agencies, they indicated that they were getting what they needed from our facility," Jones says.

Using the Situation-Background-Assessment-Recommendation (SBAR) form, the hospital's readmission reduction team created SBAR pocket cards as a tool to help their staff effectively communicate information to the receiving facility as patients transition through the continuum. *(For details about the SBAR form, see: http://www.ihi.org/knowledge/Pages/Tools/SBARToolkit.aspx.)*

When the hospital analyzed readmissions from skilled nursing facilities, it determined that many readmissions occurred because the skilled nursing facility staff did not recognize early warning signs and symptoms that indicated a patient's condition was exacerbating. "By the time they did realize that the patient was in trouble, he or she was sick enough to be admitted," Jones says.

The TMF Health Quality Institute team educated the entire skilled nursing facility staff, beginning with the housekeepers, to recognize subtle changes in the patients. "The housekeepers probably spend more time with the patients than anybody. We educated them on the signs to watch for and when to notify the nursing staff of slight changes," Jones says. ■

## CNE OBJECTIVES & INSTRUCTIONS

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.

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. ■

## COMING IN FUTURE MONTHS

■ Everything you need to know about value-based purchasing.

■ How to extend case management beyond the hospital walls.

■ Why case manager-hospitalist relationships are so important.

■ The whys and hows of emergency department case management.

# CNE QUESTIONS

1. CMS is considering adding new measures to the readmission reduction program in fiscal 2015. What are some of the measures under consideration?
   A. Chronic obstructive pulmonary disease, coronary artery bypass grafting, percutaneous transluminal coronary angioplasty.
   B. Coronary artery bypass grafting, sepsis, implantation of cardiac electronic devices.
   C. Kidney and urinary tract infections, chronic obstructive pulmonary disease, total hip and total knee replacement.
   D. All of the above.

2. According to Carol Levine, director of the Families and Health Care Project for the United Hospital Fund, case managers should assume that the patient's caregiver is the person listed on the chart as "next-of-kin" or "contact person."
   A. True
   B. False?

3. Under the Centers for Medicare & Medicaid Services' readmission reduction program, when will reimbursement cuts begin for hospitals with excess readmissions for heart failure, AMI, and pneumonia?
   A. Jan. 1, 2013
   B. Oct. 1, 2013
   C. Oct. 1, 2012
   D. Jan. 1, 2014

4. The University of Michigan Hospitals and Health Centers reduced its overall readmission rate from 20% to 17.4% by concentrating on what group of patients?
   A. Frail elderly Medicare recipients.
   B. Patients with heart failure, diabetes, or coronary artery disease.
   C. All patients who have been hospitalized or had an emergency department visit.
   D. Patients under age 65 who have complex medical and psychosocial needs.