HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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Focus on overall quality to succeed under value-based purchasing

CMS is adding more measures as time goes on

As reimbursement adjustments under the Centers for Medicare & Medicaid Services' (CMS) Value-based Purchasing (VBP) Program start to kick in this October 1, it's more important than ever for case managers to be pay attention to overall quality improvement and not just concentrate on particular patients or conditions, says **Danielle Lloyd**, MPH, vice president for policy development and analysis for the Premier healthcare alliance, with headquarters in Charlotte, NC.

"The big picture is that we are going to a world where care is more coordinated, more efficient, and more accountable. Case managers have been focused on efficient use of resources, transitions of care and discharge coordination for a long time, and they are well positioned to take a lead in their hospitals' initiatives," adds **Richard Bankowitz**, MD, MBA, FACP, enterprise-wide chief medical officer for Premier.

Under VBP, all hospitals will receive a 1% reduction in their base operating DRG payment for all Medicare fee-for-service discharges, not just those selected for the VBP initiative. The reduction goes up by ¼ percentage point for each subsequent year until it reaches 2% in 2017, but hospitals can earn bonuses by performing well. Hospitals that per-

EXECUTIVE SUMMARY

The move toward value-based purchasing by the Centers for Medicare & Medicaid Services means that hospitals need to focus on overall quality improvement rather than limiting their efforts to just a few conditions.

- To keep the initiative budget neutral, CMS is reducing the base operating DRG payment for all Medicare fee-for-service discharges, but hospitals can earn bonuses by performing well.
- CMS intends to add more measures in the future and can include any measures already being tracked in the Inpatient Quality Reporting Program.
- Medicare spending per beneficiary will be part of value-based purchasing in fiscal 2015 and will hold hospitals accountable for costs incurred by patients beginning three days before admission to 30 days after discharge.

form well on quality measures chosen by CMS or improve their baseline performance on the measures during a performance period would receive value-based incentive payments.

The Value-based Purchasing Program is designed to be budget-neutral, with a set amount of money that can be shifted around, Lloyd says. This means that when some hospitals fall short, others can get a bonus. CMS estimates that some hospitals can get as much as a 1% bonus, while others are getting close to a 1% reduction in payment for all DRGs in the first year of the program, she adds.

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, points out that hospitals that perform poorly on the CMS readmission reduction initiative and the VBP measures could lose as much as 2% of all Medicare reimbursement in fiscal 2013. That figure could rise to 5% by fiscal 2017.

"Medicare is intent that hospitals do everything they can to ensure that patients have a smooth transition," Wallace says. "If hospitals do a better job coordinating care while patients are in the hospital and in ensuring successful care transitions, they can also reduce excess readmissions and avoid that payment reduction as well as performing better on value-based purchasing," she adds.

Value-based purchasing measures for fiscal 2013 includes 12 clinical process-of-care measures and eight patient experience measures. CMS is adding three outcomes measures — 30-day all-cause mortality for heart failure, pneumonia, and acute myocardial infarction — to value-based purchasing in fiscal 2014. It has announced its intentions to add additional measures for fiscal 2015, including Medicare spending-per-beneficiary, which aggregates all Medicare Part A and Part B spending on a patient beginning three days before admissions and continuing until 30 days after discharge.

Wallace points out that the number of measures included in value-based purchasing is going to increase in future years. "Anything that is part of the Inpatient Quality Reporting program is subject to being included in value-based purchasing in the future. CMS is transitioning to an active purchaser of healthcare and views these measures as being indicative of higher quality patient care," she says.

This means that hospitals can't just concentrate on improving their performance on measures that CMS has already included in the Value-based Purchasing Program. Value-based purchasing needs to be part of a broad quality improvement project. Hospitals need to look ahead to the future and the measures that CMS has proposed adding over time, she says.

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"Since in the proposed rule for the Inpatient Prospective Payment System for fiscal 2013, CMS discusses value-base purchasing measures for 2015, hospitals may think they've got a lot of time to prepare, but the performance periods for 2015 start in October 2012 and January 2013, depending on the measure," she says.

Lloyd adds: "It's important to remember that the measurement period is well in advance of the payment period. Hospitals can't wait until the payment years to take steps to improve their quality." For instance, for measures that will be taken into consideration for hospital reimbursement beginning in October, the baseline period was July 1, 2009, to March 31, 2010, and the performance period was July 1, 2011, to March 31, 2012. *(For a look at what two Texas hospitals learned from the CMS/Premier Hospital Quality Incentive Demonstration value-based purchasing project, see related article on page 116.)*

Elizabeth Lamkin, MHA, chief executive officer and partner in PACE Healthcare Consulting, LLC, based in Hilton Head Island, SC, points out that value-based purchasing gives hospitals an opportunity to profit if they perform better than their peers, but they need to have a strong care management department in order to do so. "Hospitals have to get their houses in order right now to survive in the future. It's all about becoming a really safe and reliable hospital," she says.

Value-based purchasing, the Recovery Audit Program, and the readmission reduction program have all elevated the roles of the case management department and physician advisor working as a strong team, she adds. "Case managers really bring everything together. They are in the chart, looking at documentation and have the opportunity to work with physicians and documentation improvement specialists to improve the documentation. Case managers review what is going on in the clinical areas and have the opportunity to improve communication between the care providers and patients and families, and we know that helps patient satisfaction," Lamkin says.

The financial impact of case managers has skyrocketed and that's the case that case management directors need to make to administration, Lamkin says. "Especially now that value-based purchasing is going into effect, case managers need to demonstrate how they affect clinical, patient satisfaction, and efficiency measures as well as controlling length of stay and outliers and avoiding denials by getting medical necessity correct on the front end," she says.

Lamkin recommends that case managers work as a team with the clinical staff, physicians, patient services, finance, and ancillary services and establish interdisciplinary team conferences in which the entire team reviews cases. "Case management is truly the opportunity to ensure that the financial side and the clinical side work together," she says.

Case managers need to broaden their thinking about care coordination and take a patient-centered approach as they act as advocates for their patients, Bankowitz says. The patient-centered approach should be explicitly defined in the job descriptions and responsibilities for case managers, he says.

"Most patients don't want care that is not effective or efficient. They don't want procedures with no value and don't want a specialist consultation when it's not necessary. As they coordinate care on a daily basis and when they create discharge plans, case managers have the opportunity to ensure that the care patients receive is effective and cost-efficient," Bankowitz says.

Work closely with hospitalists and the rest of the treatment plan and look beyond discharge planning to the bigger picture of coordinated care, Bankowitz says.

"It's going to take a team effort among the case managers, social workers, nurses, and hospitalists to determine how best to deliver value," he says. ■

Hospitals and post-acute care under VBP

Good discharge planning crucial for success

Beginning with discharges on and after Oct. 1, 2014, hospitals will be held accountable for not only the cost of care they provide for Medicare beneficiaries but also for the cost of services provided by rehabilitation hospitals, skilled nursing facilities, home health agencies, and other post-acute providers for 30 days after patients are discharged.

The new Medicare spending-per-beneficiary measure is designed to evaluate how efficiently care is delivered when patients are in the hospital and the effectiveness of the discharge plans they develop. The measure will be added to the Centers for Medicare & Medicaid Services' Value-Based Purchasing Program beginning in fiscal 2015.

Under the Medicare spending-per-beneficiary

initiative, every Medicare Part A and Part B claim incurred by the patient beginning three days before discharge through 30 days after discharge is included in the Medicare spending-per-beneficiary ratio. Medicare Part D expenditures are not included.

CMS will get a total of claims data for the entire episode of care and adjust it based on the patient's age and severity of illness. The sum of all payments will be divided by the number of episodes, and that figure will be compared with the median Medicare spending-per-beneficiary amount across all hospitals.

"CMS is taking steps to incentivize hospitals to do a better job in managing the patient's length of stay while they are in the hospital as well as improving transitions in care. Both contribute to how much is spent during the entire episode of care," 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.

The Medicare spending-per-beneficiary measure means that case managers need to ensure that patients have successful transitions in care as well as making sure that documentation includes details that indicate severity of illness and services received, Wallace says. Many value-based purchasing measures are risk-adjusted, which means it is extremely important that documentation clearly indicates how sick patients are, she says. "It only makes sense that it costs more to treat patients who are sicker, and the risk-adjustment process is intended to reflect that. If a hospitals' documentation inadequately portrays patients' severity of illness, they are likely to have unfavorable results under this measure," she adds.

Hospitals may have little control over what happens after patients are discharged, Wallace points out. However, she adds, CMS emphasizes that physician practices and the availability of community resources have a lot to do with what happens to patients after discharge. "CMS has indicated that hospitals can have the most effect on Medicare spending by providing good care while the patient is in the hospital and developing effective care transition plans," she says.

The performance period for spending per beneficiary started May 1, 2012, Wallace says. "Even though this won't be included in value-based purchasing until fiscal 2015, hospitals need to start now to make sure the documentation is complete and that they develop workable transition plans for all patients," she says.

Danielle Lloyd, MPH, vice president for policy development and analysis for the Premier healthcare alliance points out that it's possible for two different patients in two hospitals to have the same amount in claims for an inpatient stay, but when the total cost of care is tabulated, the sums could vary greatly. "One patient could have a physician who relies more on skilled nursing stays after discharge and the other hospital's physician might prefer discharging patients to home with home health services instead," she says.

Under Medicare spending-per-beneficiary, case managers should work closely with the treatment team and the patient and family to develop discharge plans that are cost-effective and that meet the needs of each individual patient, Lloyd adds.

Keep in mind that care doesn't end at the hospital's doorstep. "Case managers need to extend their reach and take a fresh view of how to coordinate care after discharge," she says.

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To succeed at VBP, focus on improving clinical care

Good communication boosts patient satisfaction

As hospitals struggle to become more efficient because of reduced reimbursement from Medicare, Medicaid, and commercial payers, they must continuously work to improve processes everywhere, from supply chain management to ensuring the best contracts for medication and equipment to the most efficient use of beds, and moving patients quickly through the continuum, says **Joseph Prosser**, MD, chief quality officer at Texas Harris Methodist Hospital Fort Worth and Texas Health Harris Methodist Hospital Azle. Both hospitals are part of Texas Health Resources,

a faith-based nonprofit healthcare delivery system in North Texas and participated in the CMS/Premier Hospital Quality Incentive Demonstration value-based purchasing project on which the Value-Based Purchasing Program is based.

According to Premier, hospitals that participated in the demonstration project raised their overall quality and scored higher than non-participating hospitals on the measures covered by Hospital Compare.

The secret to success in value-based purchasing is to focus on improving all clinical measures, not just those currently in value-based purchasing or on the Hospital Compare scorecard, Prosser says.

"All of the hospitals in the Texas Health Resources system have a relentless focus on clinical measures and on making sure everybody gets perfect care every time. From the clinical perspective, we have worked to reduce variation in clinical practice and to make sure the patients get the recommended care they need. On the patient satisfaction side, we begin to plan the discharge on Day 1 and don't wait until the end of the stay to hit patients with the fact that they're not going home. This is crucial to achieving good patient throughput as well as contributing to patients' satisfaction with their experiences in the hospital," he says.

When the CMS project began, the hospitals created multidisciplinary task forces to look at opportunities for improvement. "We know the best practices for each clinical indicator and look for opportunities to improve performance by continuously measuring and educating our physicians, nurses, and ancillary staff," he says.

The multidisciplinary teams also look at the best practices and focus on ways to reduce variation among physicians. "This is a long-term, ongoing continual performance improvement project that never ends as the science of medicine evolves," he says.

One initiative is to include prompts in the medical record to remind clinicians of the care patients need and the appropriate sequences. "Humans occasionally forget or are tired, and having a tool on the electronic medical record helps make sure nothing falls through the cracks. The high-performing healthcare organizations use multiple approaches to ensuring the delivery of exceptional care. Because of the diverse number of physicians and nurses, we can't rely on any single solution," he says.

The hospitals create regular reports on performance on clinical indicators and share the information with physicians and their peers. "In addition, I spend my time showing results to physicians to remind them on the need to take extra minutes with the patients so they can get their questions answered and feel valued as humans," he says.

The hospitals have a discharge planning task force that includes senior leadership and medical management which meets monthly to develop action plans to improve the discharge process. They look at the efficiency of internal and external communications. Medical management meets with post-acute providers to improve communication and improve the discharge process.

The task force developed a process improvement project to ensure that discharge planning begins as soon as patients are admitted. "We have emphasized for years that the patients' journey needs to be assessed, evaluated from the moment they come in the hospital door," Prosser says. Case managers know quickly if patients will be able to be discharged home or if they will need post-acute services. "We work with patients, family members, and surrogates on Day 1 to help them become familiar and comfortable with the discharge plan and the fact that the patient is not going home in the same condition he or she came in with. Good communication throughout the stay is the key to improving patient satisfaction," he says. ■

Pilot slashes ED visits by Medicaid recipients

Care plans, CM follow-up were keys

A pilot program at MetroHealth Medical Center in Cleveland resulted in significant drops in emergency department visits among Medicaid recipients who were "ultra-users" of emergency care and participated in the one-year study.

The study, which included development of care plans for each patient and counseling with case managers in the primary care office, was part of a statewide initiative by Ohio Medicaid to reduce inappropriate emergency department usage.

In the year of the pilot, there was a 44% reduction in use of the MetroHealth Medical Center emergency department by the patients in the program. When visits to other hospitals in the greater Cleveland area were taken into account, the patients in the pilot reduced their emergency

EXECUTIVE SUMMARY

Medicaid recipients in a pilot project at MetroHealth Medical Center in Cleveland, OH, reduced their emergency department visits significantly.

- Working with primary care physicians, the hospital staff drew up care plans for each patient and entered them into the medical record so they would be available to the emergency department staff.
- Participating Medicaid Managed Care Plans embedded case managers in primary care offices to educate the patients on appropriate use of the emergency department.
- The pilot has ended but the hospital and managed care plans continue to collaborate on managing patient care.

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department visits by 29%. Many of the patients who visited other emergency departments were seeking narcotics and had been turned down at MetroHealth's emergency department, according to **Alice Stollenwerk Petrulis**, MD, medical director for care management at the 500-bed medical center, a safety net public hospital. About 40% of MetroHealth Medical Center's patients are Medicaid recipients.

For the pilot, MetroHealth Medical Center analyzed emergency department use by Medicaid beneficiaries and chose five "ultra-utilizers" for each of the three Medicaid Managed Care plans that covered its patient population. "All of the patients in the pilot were frequent users of our emergency department, but some occasionally went to emergency departments at other hospitals. We chose patients who already had a primary care provider," she says.

Petrulis worked with the patients' primary care providers, a hospital social worker, and the case managers from the health plans to develop a concise care plan for each patient in the pilot and entered it into the patients' medical records where the plans would be seen by the emergency department staff.

The care plans, based on the patients' medical histories and interventions, were bullet points that included information such as "no narcotics to be given except by the primary care physician," and "has had multiple MRIs and CT-scans and doesn't need more." In some instances, the care plan requested that the emergency department staff obtain current contact information for the patient.

Instead of having a black header like the majority of patient records, charts for patients in the pilot had a red header to alert the staff that the patient had a care plan.

During the pilot, the health plan assigned case managers to provide intensive care coordination for patients in the pilot. The case managers made sure the patients had primary care appointments, called them to remind them of the appointments, arranged transportation as needed, and in some cases, went to patients' homes and accompanied them to the appointments. When patients didn't have telephones, the case managers gave them preprogrammed cell phones that they could use to call the case manager or the primary care provider but no one else.

During the one-year pilot, Petrulis met monthly with each plan, reviewed the patients and their emergency department visits, and looked for ways to make sure the patients got the care they needed to stay out of the emergency department. "In some cases, the patients didn't know that they could call their doctor to ask questions instead of visiting the emergency department, and education was enough to curb their excess use of the emergency department," she says.

Collaboration with the health plans was helpful because they had access to claims if the patients visited other emergency departments, Petrulis says.

"The program provided a lot of value to the emergency department staff because the care plans gave them the whole picture of the patient at a glance. The payers saved a lot of money because of the decrease in emergency department visits. The primary care physicians gained better relationships with their patients, but the hospital lost out on fee-for-service payments for emergency department visits," she says.

As a result of the pilot, Ohio Medicaid decided to go forward with the program on a statewide basis and include a cost-sharing component in the program to compensate the hospitals for loss of fee-for-service payments when the emergency department visits were decreased.

"The state learned that avoiding emergency department usage penalizes providers as well as learning the case managers can make a huge difference in ensuring that patients are treated at the appropriate level of care," she says.

The pilot has ended, but the hospital and the managed care plans are still collaborating on ways to keep patients from using the emergency department inappropriately. "They call me if they see a frequent flyer in the emergency department so we can put together a care plan. The emergency department staff does the same. It has been an

CASE MANAGEMENT INSIDER
Case manager to case manager

The Role of Case Management in an Era of Healthcare Reform – Part 2

By **Toni Cesta**, PhD, RN, FAAN
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As we discussed last month, healthcare reform has changed the landscape of healthcare and of case management. Emerging trends and changes related to reimbursement, readmissions, pay for performance, outcomes and newly contracted reviewer agencies such as the Recovery Audit Contractors (RACs), have changed familiar payment methods and audits to new and different ones in a short amount of time.

The definition of quality of care is now tied to reimbursement so that hospitals that do not perform as well as their peers on a variety of indicators will not get full payments and may even have to return money to CMS (the Centers for Medicare & Medicaid Services).

This month, we will continue to review the healthcare reform changes most pertinent to case managers, both now as well as over the next several years.

Current Payment Splits

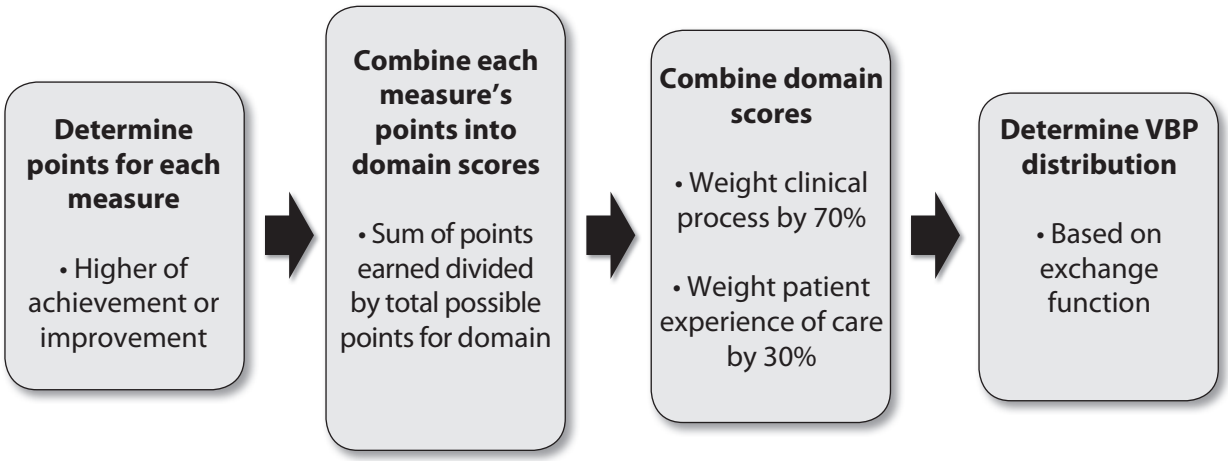
Currently, CMS has divided the weighting of the value based purchasing scores for FY 2013 as follows:

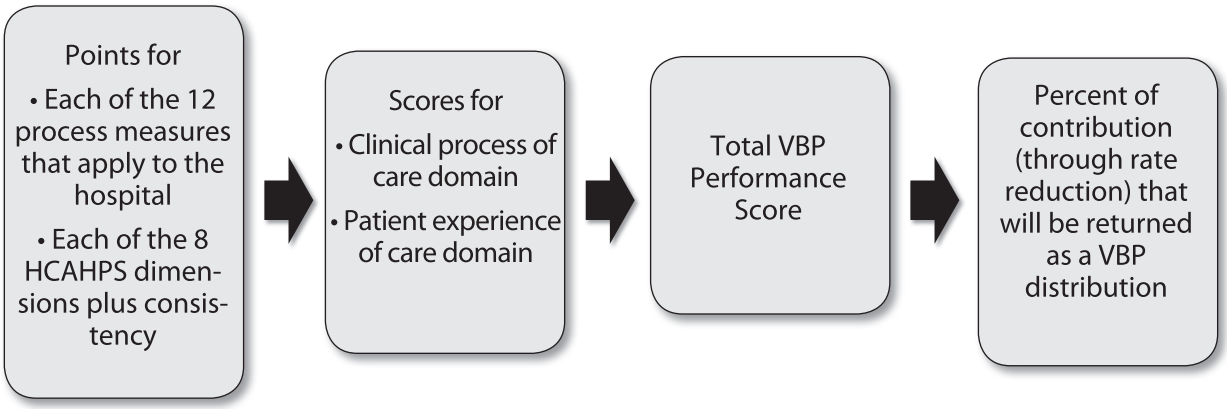
- 70% applied to processes of care (core measures)
- 30% applied to patient satisfaction

The combination of these provides the total performance score. Hospitals can earn back part of the withheld payments based on their performance in these areas.

Processes of Care (Core Measures)

There are a variety of "process of care" measures. They are discussed below with their performance measures.





Hospital Process of Care Measure Set

The process of care measures are also known as the core measures. Hospitals are required to follow these measures 100% of the time.

List of Current Measures:

Heart Attack (Acute Myocardial Infarction or AMI) and Chest Pain

- Aspirin at Arrival (Is both an inpatient and outpatient measure.)
- Aspirin at Discharge
- Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) for Left Ventricular Systolic Dysfunction
- Beta Blocker at Discharge
- Fibrinolytic Medication Within 30 Minutes Of Arrival (Is both an inpatient and outpatient measure.)
- Percutaneous Coronary Intervention (PCI) Received Within 90 Minutes of Hospital Arrival
- Smoking Cessation Advice/Counseling
- Median Time to Fibrinolysis (This is only an outpatient measure)
- Median Time to Transfer to Another Facility for Acute Coronary Intervention (This is only an outpatient measure.)
- Median Time to ECG (This is only an outpatient measure.)
- Statin at Discharge

Surgical Care Improvement Project

- Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision (Is both an inpatient and outpatient measure.)
- Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
- Prophylactic Antibiotic Selection (Is both an inpatient and outpatient measure.)
- Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
- Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery
- Cardiac Surgery Patients With Controlled 6 A.M. Postoperative Blood Glucose
- Surgery Patients with Appropriate Hair Removal
- Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
- Inpatients whose urinary catheters were removed within 2 days after surgery to reduce the risk of infection.
- Surgery Patients with Perioperative Temperature Management

Heart Failure

- Evaluation of Left Ventricular Systolic (LVS) Function
- Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) for Left Ventricular Systolic Dysfunction
- Discharge Instructions
- Smoking Cessation Advice/Counseling

Pneumonia

- Initial Antibiotic Timing
- Pneumococcal Vaccination
- Influenza Vaccination
- Blood Culture Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
- Appropriate Initial Antibiotic Selection
- Smoking Cessation Advice/Counseling

Case Managers and Core Measures

While most case managers are not directly responsible for managing core measures, case managers can still play an important role in watching for compliance gaps in their day to day work. Additionally, some hospitals include some concurrent core measure review into the role of identified members of the interdisciplinary care team. For example, concurrent core measure review may be a responsibility of the clinical documentation improvement specialist (CDI). This combination of roles makes sense when you think of it in terms of the diagnoses targeted for CDI and those that have core measures associated with them.

Hospital Acquired Conditions (HAC) – Also Known as "Present on Admission"

For discharges occurring on or after Oct. 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis were not present. An example of how the HAC provision may affect an MS-DRG payment, beginning Oct. 1, 2008, is presented below.

CMS also required hospitals to report present on admission information for both primary and secondary diagnoses when submitting claims for discharges on or after Oct. 1, 2007.

As can be seen by the examples above, these hospital-acquired conditions can have a large impact on the final reimbursement for these specific MS-DRGs. Clinical documentation specialists and case managers can play a role in identifying gaps in documentation associated with issues that were present on admission but not adequately documented. This process should be considered as one of the components of the role of the emergency department case manager, who is likely to be the first case manager to see the patient upon arrival to the hospital.

Meaningful Use

The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Sometimes people use the terms "electronic medical record" or "EMR" when talking about electronic health record (EHR) technology. Very often an electronic medical record or EMR is just another way to describe an electronic health record or EHR, and both providers and vendors sometimes use the terms interchangeably. For the purposes of the Medicare and Medicaid Incentive Programs, eligible professionals, eligible hospitals and critical access hospitals (CAHs) must use certified EHR technology. Certified EHR technology gives assurance to purchasers and other users that an EHR system or module offers the necessary technological capability, functionality, and security to help them meet the meaningful use criteria. Certification also helps providers and patients be confident that the electronic health information technology products and systems they use are secure, can maintain data confidentially, and can work with other systems to share information.

Eligible hospitals may receive incentive payments for up to four years, beginning with fiscal year beginning 2011 (Oct. 1, 2010 – Sept. 30, 2011), provided they successfully demonstrate meaningful use of certified EHR technology.

Eligible hospitals may qualify to receive pay-

Primary and Secondary Diagnoses		
MS-DRG Assignment	**Present on Admission**	**Average Payment**
Principal Diagnosis MS-DRG 066 : Intracranial hemorrhage or cerebral infarction (stroke) without CC/MCC	--	$5,347.98
Example Secondary Diagnosis Dislocation of patella-open due to a fall: MS-DRG 065 Intracranial hemorrhage or cerebral infarction (stroke) with CC	Y	$6,177.43
Principal Diagnosis - Stroke Example Secondary Diagnosis Stage III pressure ulcer (MCC): MS-DRG 064 Intracranial hemorrhage or cerebral infarction (stroke) with MCC	Y	$8,030.28

ments from both the Medicare and Medicaid EHR Incentive Programs.

A qualifying hospital is an eligible hospital that successfully demonstrates meaningful use of certified EHR technology for the EHR reporting period during a payment year. A Payment Year is a Federal Fiscal Year (FFY).

For the first year an eligible hospital demonstrates meaningful use of certified EHR technology, the EHR Reporting Period equals any 90 continuous days beginning and ending within the year. For every year thereafter, the EHR reporting period is the entire year.

Eligible hospitals may qualify to receive incentive payments for up to four years beginning in FY 2011. The last year for which an eligible hospital can begin receiving incentive payments for this program is 2015.

The incentive payment for each eligible hospital will be calculated based on:

1. An initial amount which is the sum of a $2 million base amount and the product of a per discharge amount (of $200) and the number of discharges (for discharges between 1150 and 23,000 discharges);

2. The Medicare share which has as its numerator Medicare fee-for-service and managed care acute-care inpatient bed-days and as its denominator the product of total acute care inpatient days and the percentage of hospital's total charges that are not attributed to charity care; and

3. A transition factor which phases down the incentive payments over the four-year period.

As a case management professional, you may not have any direct responsibilities related to meaningful use. The information provided here will allow you to understand why and how your employer is engaged in meaningful use activities through the implementation of an electronic health record at your organization.

At the same time, case management departments should be sure to be included in any discussions concerning the use and integration of an EHR as it relates to where and how they document, as well as how an existing or future case management software application might related to the electronic health record. If these discussions don't take place, there is the potential for the case managers and social workers to have to document in two places, in the electronic health record and in their own case management software application. This would obviously not be the most efficient use of either software application or of the time of the case management staff.

Next month's issue will continue with a review of additional indicators associated with value-based purchasing and healthcare reform. Included will be:

- HCAHPS Scores
- Mortality Scores
- The new efficiency of care measure! ■

excellent program in terms of helping us collaborate. Before the pilot, neither the health plan nor the hospital knew who to call when we identified inappropriate use of the emergency department," she says. ■

Effectively transferring patients to rehab

Make sure patients are ready for PT

To prevent readmissions when patients are transitioning from the acute care hospital to an inpatient rehabilitation center, case managers should make sure the patients are appropriate for acute rehab, that their medical conditions are stable, and that they can tolerate three hours of physical therapy every day.

"It's challenging to successfully transition patients from acute care to inpatient rehab, and there are a number of factors that could result in the patient returning to the acute care hospital or being transferred to the emergency department for evaluation and treatment," says **Lori S. Aylor**, BSN, MSN, CRRN, chief nursing officer, at UVa-HealthSouth Rehabilitation Hospital, a 50-bed inpatient rehabilitation hospital in the University of Virginia Health System in Charlottesville, VA.

Communication is a key component of successful transitions, and making sure that the receiving facility has a detailed and complete discharge summary can help avoid an emergency room visit or readmission, adds **Karion G. Waites**, DNP, RN, CRRN, BS-FNP, nurse practitioner at Spain Rehabilitation Center, a 47-bed inpatient rehabilitation hospital that is part of the UAB Health System in Birmingham, AL. "Complex issues shouldn't necessarily delay transition. Even very complex patients will do very well if they are stable enough to get started in rehab, but there needs to be much better communication between the sending hospital and the receiving rehabilitation facility," she says.

When patients are being transferred, make sure your documentation is complete, legible, and, in addition to details on medical issues, includes information about the patient's behavior at different times of the day during the last few days in the hospital, Aylor and Waites suggest.

"Knowing if someone's mental status has waxed and waned or that they become agitated and confused at night helps us prepare for them and avoid sending them back," Aylor says. If the patient is agitated or confused and the discharge summary doesn't mention any problems, the rehab facility staff have to try to figure out what is causing it, and most of the time they send the patient to the emergency department to rule out any additional medical issues, she says.

Patients with urinary tract infections also get confused when they come to a new facility. "If we don't have a diagnosis that indicates the reason for the confusion, we have to rule out other complications such as stroke, and this means a trip back to the hospital," she says.

When you gather the hospital records to send to rehabilitation, include any information you have on family dynamics, particularly if the family members are anxious, if the patient doesn't have a good support system, or if a caregiver might do something harmful, such as wanting to do everything for the patient during rehab.

"The way people cope is so different. Rehab patients and family members are learning a new reality and new skills. If we have an idea of the patient's situation at home and how the family has been behaving, it gives us a good starting point for working with them," Aylor says.

The nurses say that it is helpful if case managers in the inpatient setting start educating patients and family members about the rehab process and how it differs from the acute care hospital and other post-acute facilities. "A lot of case managers compare rehab facilities to skilled nursing facilities and they're not the same thing. What patients need to know about rehab is that they will be seeing a physician every day and participating in three hours of therapy each day. Rehab is a very different level of care," Waites

EXECUTIVE SUMMARY

Patients who return to the acute care hospital after rehab often did not meet criteria for acute rehabilitation services.

- Include detailed documentation in the discharge summary, including information on the patient's behavior and mental status at different times of the day.
- Educating the patient and family about how rehab is different from acute care helps them adjust quickly to the new level of care.
- Make sure patients are medically stable and can tolerate three hours of rehab a day.

says. It's also helpful if patients are aware that the doctors they will see in rehab are not those who treated them in the acute care setting, she adds.

Inform the patients and family members that in rehab, patients are expected to learn to do as much as they can for themselves, rather than having the staff or family members to do it for them. Prepare the family to understand that if patients don't demonstrate functional improvement in rehab, they probably will need to go to another level of care.

If patients have had an amputation, Waites recommends that they have an ultrasound to check for clots and remain in the hospital until they no longer need bed rest. "We can work with an anticoagulation regimen, but we don't want to keep patients in bed for several days. If bed rest is indicated, we send them back to the acute setting," she says.

If the hospital removes a patient's Foley catheter before transferring the patient, make sure he or she has voided and that it is documented in the medical record.

Make sure patients are up on their pain medications so they don't arrive in a lot of pain. If patients take medication that requires food, the hospital should either back off the medication before transfer or give them something to eat. "It takes time for the rehab hospital to get orders in place after the patient arrives," Aylor says. ■

Conditions could result in readmit from rehab

Make sure patients are medically stable

Rehab facilities often send patients back to the acute care hospital when they are not medically stable enough to participate in rehab, says **Karion G. Waites**, DNP, RN, CRRN, BS-FNP, nurse practitioner at Spain Rehabilitation Center in Birmingham.

"Medical issues out-trump the rehab situation. We can handle patients with complex medical issues, but if their medical condition will interfere with three hours of rehab a day, they're not suitable for rehab," she says.

Here are some examples of issues that indicate patients may not be appropriate for acute rehab:

• **High oxygen demands.** Patients on two liters of oxygen may be able to tolerate rehab, but it is cumbersome to drag an oxygen tank to therapy. "If patients still need three to four liters of oxygen at rest, they won't be able to maintain proper saturation when they exercise," Waites says.

• **Bed sores or fractures of weight-bearing limbs.** These patients need to time to heal before they can participate in rehab. "There's not a lot of we can do during the healing process, but once the patient can bear weight or sit up comfortably, we can work on mobility and transfers," Waites says.

• **Intravenous pain medication.** Heavy doses of pain medication can make patients drowsy and increase the risk of falls. Patients need to transition from IV pain medication to oral medication before transferring to rehab. Waites recommends that patients be placed on oral medication for a few days before going to rehab to make sure the patients can tolerate pain when they sit up and start moving. Patients on high doses of pain medication may become constipated, experience bowel blockage or become nauseated and not able to participate in rehab.

• **Lack of activity in the hospital.** If patients have not gotten out of the bed and built activity tolerance during the hospital stay, just the process of transferring them by ambulance to the rehab center may exhaust them. "It's amazing how much stress and pressure the transition puts on patients. Many people become completely fatigued by the transfer itself. It's not unusual for us to send patients back to the hospital within hours if they have not sat up on the bed in the hospital and are exhausted by the transfer," says **Lori S. Aylor**, BSN, MSN, CRRN, chief nursing officer, at UVa-HealthSouth Rehabilitation Hospital, in Charlottesville, VA.

Encourage patients to increase their activity every day while they are in the hospital to build tolerance. You don't want to test the patient's ability to tolerate activity when they are put on the stretcher to transfer to rehab.

• **Malnourished patients.** If patients have problems eating and drinking enough to sustain themselves, they are unlikely to get enough added nutrition for the exercise they need during rehab. Patients with nasogastric tubes don't do well in rehab. Percutaneous endoscopic gastrostomy (PEG) tubes are more appropriate for rehab, but patients need to make the transition to nocturnal feedings which don't interfere with therapy, Aylor says. Patients who have problems tolerating tube feeding may need to be readmitted if

they experience unresolved fullness, diarrhea, or abdominal pain.

• **Medical instability.** Patients who are experiencing atrial fibrillation, unstable vital signs, or elevated blood pressure may not tolerate a transfer well. Patients with infections or poorly healing wounds may have an underlying medical condition that will inhibit their ability to tolerate rehab. Patients who need long-term IV antibiotics or frequent blood draws are not suitable for rehab. ■

Managing HF patients throughout continuum

Team works with payers, providers

At St. Joseph's Hospital in Tampa, a multidisciplinary team collaborates with clinicians throughout the continuum to manage the care of heart failure patients.

In the new program, the hospital has worked with HealthPoint Medical Group to develop a comprehensive program that provides individualized treatment for heart failure patients.

"Heart failure represents a growing population of patients, as well as being the most expensive group of patients receiving Medicare benefits. Tampa has a readmission rate for heart failure that is higher than the national average. This makes us very interested in determining why these patients continue to be admitted and readmitted to the hospital and to help them learn to manage their disease," says **Gus Agocha**, MD, PhD, director of the Congestive Heart Failure Care program.

The heart failure team includes Agocha, a nurse case manager, and a nurse practitioner who work with the cardiologists who treat patients in the hospital, the hospital's heart failure nurse advocate who provides care coordination and education to heart failure patients in the hospital, and primary care physicians in the community. "Our program is collaborative and transcends the hospital walls. We emphasize to clinicians throughout the continuum that we are not coming in and taking over care. We are coordinating a uniform care plan to make sure everybody is on the same page and is giving the same message to the patients," he says.

The program provides a central telephone number that all clinicians, patients, and family members can call whether the patient is in the hospital, in the home, the physician's office, or a skilled nursing facility, Agocha says. The program is only a few months old, but the team already has anecdotal data to show that patients are calling the heart failure nurse instead of going to the emergency department.

"We are available if caregivers or providers have questions or concerns. If the nurses in the hospice program or the home healthcare agency have questions, they know to call us. Patients sometimes end up in the emergency department because the home health nurse has questions and can't get in touch with the primary care physician. Now they can call us," he says.

When patients are hospitalized with heart failure, Agocha meets with the attending physician and talks with the patient's primary care physician to discuss the patient, then reviews the medical record and the patient's history. The team develops a care plan consistent with the patient's stage of heart failure.

"When patients are frequently admitted, it helps to have a set of fresh eyes to look at what is going on. In addition it is helpful for me to have a conversation with a physician who has managed the patient for a long time to get their thoughts. Together we can come up with a plan for the patient," Agocha says.

The heart failure team sees every heart failure patient in the hospital. Agocha meets with them initially and educates them about their disease and medication. Then, the nurse case manager follows up and reinforces the teaching, conducting lifestyle counseling to help the patient improve diet and exercise and manage smoking habits.

"What is lost in a lot of education is the fact that heart failure is progressive. We educate patients to understand that if they follow their treatment plan, they can slow down the progress of heart failure so much that it seems like it stops," he says. The team uses diagrams and pictures to show patients and family members what happens as the disease progresses to emphasize why it's

EXECUTIVE SUMMARY

At St. Joseph's Hospital in Tampa, a special heart failure team works with clinicians throughout the continuum to ensure patients get optimum care.
- Collaborative program transcends hospital walls.
- Team works with cardiologists and community physicians to develop care plan.
- Patients, family members, and providers can call a central number with questions.

important for them to follow the treatment plan.

When patients are discharged, they come to the heart failure clinic, located next to the hospital, within three to five days. The team makes sure they have filled their prescriptions and that they know who to call if they gain weight or experience other symptoms.

Many heart failure readmissions occur because patients aren't seen by a medical professional in a timely manner, Agocha says, adding that about 80% of heart failure patients who come to the emergency department are admitted.

"Our goal is to see patients early enough and to work with them and their providers to cut down on the readmissions. We are absolutely focused on the patient and making sure they understand what they need to do. Currently there is not cure for heart failure, but we can help patients slow the progress of the disease," he says. ■

New survey tools for patient safety COPs

Nationwide pilot under way

For years, the Centers for Medicare & Medicaid Services (CMS) state operations manual has had guidelines for surveyors to assess issues related to patient safety at hospitals. But there is such a wide range in size and scope of hospitals, says **Marilyn Dahl**, CMS director of the division of acute care services, that the organization decided it would be a good idea to create some sort of prompt for surveyors to use.

The organization began a process a couple of years ago to create the new tools after picking three areas — infection control, quality assurance and performance improvement, and discharge planning. Expert panels helped create the guidance and tools. They included patient safety experts from a variety of organizations, and for the infection control tool, there was assistance from the Centers for Disease Control and Prevention, she says. They also used the much simpler ambulatory surgery center infection control tool as a starting point, says Dahl *(See list of sections from the discharge planning tool, page 127)*.

Piloted initially in 11 states, Dahl says, surveyors tested the tool beginning in the fall of last year. Not every state tested every tool, and all did varying numbers of surveys with them. "We have them test the tools in isolation on hospitals they identify to run them," she says. The tests are non-punitive, although statements of deficiencies were issued. But barring any findings so serious that patients were in imminent danger, no enforcement actions occurred.

Last December, with feedback from the states that did the pretests, they made some simple revisions — mostly typographical errors and changes in wording, Dahl says.

The infection control tool had the most work done, says **Daniel L. Schwartz**, MD, MBA, chief medical officer for the survey and certification group. While most of the changes were related to how the tool was organized, Schwartz says that there were some questions added, and some issues that users felt needed work. One example was that the section on hand hygiene didn't include guidance for surveyors to look for staff with long or false fingernails.

By the spring of this year, CMS was doing training with hospital accreditation organizations and providing detailed instructions to the states on doing pilot tests, says Dahl. By the end of September, every state is expected during the pilot phase to do at least one survey using each tool. They can volunteer to do more. After that, and for the next several months, CMS may ask that some test all three of the tools in a single survey.

"As surveyors become more familiar with the tools — they are very comprehensive — there is a lot of review to do," Dahl says. "If we combine all three together, is there any efficiency we can realize? Or will it be simply additive?"

The pilot will last through January, she says, and will continue to be non-punitive — again, barring any findings that show patients are in immediate danger. Examples of that would be egregious breaches in infection control, or dropping surgical instruments on the floor, picking them up and using them, Dahl explains. A facility that had a number of wrong-site surgeries but didn't have a program in place to analyze what happened or do a time out —that would be considered immediate jeopardy and a serious enough threat to patients to require punitive action.

After a last round of user feedback, the tools will be finalized, Dahl notes. "At that point, they will become a standard part of the survey process."

Hospitals that are part of the pilot program

are welcome to provide feedback, too, she adds.

National associations related to hospitals have been involved from the start in updating this guidance, and Dahl says they are very supportive of the efforts. "There is a lot that hospitals are expected to do, but these tools are assessing current regulations," she says. "In the past, we haven't been so explicit in our expectations. So while this may look like a change, it isn't. We are just outlining expectations for regulations that are already there."

Creating the tools wasn't easy. The Quality Assurance and Performance Improvement (QAPI) tool was particularly difficult. But the level of work required to create it won't preclude CMS from developing further tools. After these three have had their initial outings and been "digested," Dahl says others will be considered.

Schwartz says he would encourage hospitals to look at these tools now and use them as a guide for self assessment. He says the infection control one, in particular, is great for such activities.

They all are, Dahl says. "We want people to understand them and use them internally," she says. "It will help them do well in future surveys."

All three pilot tools are available in their entirety at http://apic.org/Resource_/TinyMceFileManager/Advocacy-PDFs/CMS_revised_hospital_surveyors_worksheets_5-18-12.pdf. ■

Discharge planning survey tool

Pre-Decisional Surveyor Worksheet
Assessing Hospital Compliance with the Condition of Participation for Discharge Planning

Pilot Program Draft Version

Section 1 – Hospital Characteristics

Section 2 – Discharge Planning – Policies and Procedures

Section 3 – Discharge Planning – Reassessment and QAPI

Section 4 – Discharge Planning Tracers

Hospital Report blog

For further analysis and discussion of topics important to hospital professionals, check out **Hospital Report**, AHC Media's new free blog at http://hospitalreport.blogs.ahcmedia.com/. *Hospital Case Management's* executive editor Russ Underwood and associate managing editor Jill Drachenberg both contribute. ■

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.

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COMING IN FUTURE MONTHS

■ What your peers are doing to reduce readmissions.

■ Why ED case management is more important than ever.

■ Extending care throughout the continuum.

■ How to partner with your hospitalist team.

CNE QUESTIONS

1. What period of time does the Medicare spending-per-beneficiary cover?
   A. 30 days before admission through three days after discharge.
   B. Three days before admission through 30 days after discharge.
   C. The day of admission plus all post-acute care.
   D. Tests and procedures at the hospital before admission plus the inpatient stay.

2. When will the Medicare spending-per-beneficiary measure become a part of value-based purchasing?
   A. Oct. 1, 2012
   B. Oct. 1, 2013
   C. Oct. 1, 2014
   D. Oct. 1, 2015

3. When Medicaid beneficiaries in MetroHealth Medical Center's pilot project to reduce inappropriate emergency department use visited other emergency departments, what was their reason for going somewhere beside MetroHealth?
   A. Other hospitals were closer.
   B. Their primary care provider recommended another hospital.
   C. MetroHealth couldn't provide the care they needed.
   D. They were turned down for narcotics at MetroHealth's emergency department.

4. According to rehabilitation hospital nurses, why are patients returned to the acute care hospital shortly after they arrive at rehab?
   A. They act confused and there is nothing to indicate the cause in the discharge summary so the rehab hospital wants to rule out a stroke or other complication.
   B. Bed rest is indicated for patients who have had an amputation.
   C. Patients have bed sores or fractures of weight bearing limbs that hinder their participation in rehab.
   D. All of the above.

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