HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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On-the-job training won't cut it any more, experts say

New CMs need formal education, mentoring

Once upon a time, new case managers received their training and orientation as they rotated through the case management department. One day they were nurses on the unit or case managers at a different hospital, and the next day, after a short orientation session, they were case managers on the unit, sometimes with a full case load.

That's still the case in some hospitals, says **Peggy Rossi**, BSN, MPA, CCM, a retired hospital case management director who now is a consultant for the Center for Case Management.

"As I work with hospitals to develop case management training, I'm finding that many have no orientation and that new case managers are assigned to several different preceptors for on-the-job training, often without consistency in their orientation. If the preceptor is doing something the wrong way, the case manager does the same thing," Rossi says.

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Catherine M. Mullahy, RN, BSN, CCRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY, case management consulting firm, encounters the same situation when she presents case manager training seminars. "I continue to hear from people both certified and not that they never received any formal training in the process of case management. Case management is so important and case managers bring such value to the hospital, saving money and increasing patient satisfaction scores. I don't understand why hospital administrators fail to recognize the value of formal education to give case managers the knowledge and the tools to do their job," Mullahy says.

Compliance requirements are so comprehensive and change so often that new case managers need extensive training, adds **Beverly Cunningham**, RN, MS, vice president of resource management at Medical City Dallas Hospital.

In addition to being responsible for care coordination, utilization management, patient status and discharge planning, in many hospitals case managers may be responsible for documentation improvement and core measures. "I don't think case managers should be the owners of financial incentives and quality care, but care coordination and collaboration with providers inside and outside the hospital do affect the hospital's bottom line and case managers need to have a clear understanding of compliance and the goals of the department as well as what case managers do on a day-to-day basis," she says.

(For a look at changes that may affect case managers that the Centers for Medicare & Medicaid Services includes in its Prospective Payment System Proposed Rule for fiscal 2014,

EXECUTIVE SUMMARY

Today's case managers need far more than on-the-job training to understand the complexities of the job and all of the tasks they must do on a daily basis.

- The length and content of the training must be geared to individual case managers and take into account their knowledge, skill set and experience.
- New case managers should be able to pass competencies and should meet with the case manager director and the person doing the training at the end of the week to discuss how the training is going.
- Hospital case managers must develop their own case management training programs that are based on hospital procedures and policies, specific job descriptions, and goals of the department, some experts say.
- In many cases, rather than hiring an experienced case manager who may not fit well into your department, it's better to hire someone with the characteristics you are looking for and teach him or her case management.

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see related article on page 95.)

"The role of case management is so complex. They have to deal with so many regulations and do so much multitasking that training is critical. Hospitals are so fast-paced that training can't cover everything, but it can give new case managers a good foundation on which to build," says **Susan M. Almes**, RN, BS, ACM, a former case manager, now a training specialist for UPMC, an integrated health system with headquarters in Pittsburgh. At UPMC, new case managers spend one to four weeks on the floor of the hospital to which they are assigned, then attend eight days of classroom training, and spend another six weeks with a preceptor before being on their own. *(For details, see article on page 93.)*

It's not sufficient to hire people, provide a week of orientation, hand them a manual, and assign them to a unit, Mullahy says. "New case managers can read books or take online courses, but until they experience working with families with problems, coordinating care for people with mental health issues, or collaborating with physicians, they can't know what the job is really like," she says.

Orientation and training depend on the people receiving the training, their experience and their knowledge base, Cunningham says. Nurses from your hospital don't have to learn the system, but they do need to learn the fundamentals of case management. People with case management experience need to learn your hospital's system, the responsibilities of case managers at your particular hospital, and how the department works.

Case management training should be a minimum of four to six weeks, even for staff who have had case management experience at other hospitals, Rossi suggests. "New case managers need to know everything the job entails and be acclimated to the hospital, its philosophy, vision, and mission statement," she says.

Case managers need to be familiar with Medicare and Medicaid, their admission and documentation requirements, continuing stay criteria, and what they cover, Rossi says. "Medicare is the grandfather of utilization, and staff need to be mindful that whatever the federal government requires, state agencies and commercial insurers will follow suit," she says.

Rossi suggests that, as part of their training, new case managers visit a local skilled nursing facility and follow a home health nurse to learn what care is provided in that setting. In addition, it is important for case managers to learn state code requirements as they pertain to post-acute providers so they can make the right discharge destination choices, she says. For instance, she points out that in California, skilled nursing facilities are required to provide only 3.2 hours of skilled nursing care a day. "If patients need more care, they're going to bounce back to the hospital," she says.

New case managers need to be able to pass competencies on hospital policies and procedures, and case managers should be able to demonstrate what they have learned before going out on their own, Rossi says. For instance, have case managers discuss when a Condition Code 44 is appropriate and demonstrate what should be done. If they get part of it wrong, repeat the lesson.

Once case managers are assigned to a unit, the orientation should include in-depth information that is specific to that unit. For instance, if the case manager sometimes will be managing the care and discharge of homeless people, the training should include information on community resources.

Cunningham suggests that case managers identify on an individual basis what they want their staff to learn and meet at the end of each week with the new case manager and the person doing the orientation. During the meeting, they should go over the goals for the past week and set new goals. "Some people will breeze through the orientation, but others may take longer. It works best to address the deficits on a weekly basis rather than waiting until the end of the orientation to find out how well it went," Cunningham says.

The weekly meetings are time well spent for a leader and satisfying for the new staff member, Cunningham says. "This way everyone is on the same page and we all know exactly where we are. If nobody gives feedback, you may assume everything is going smoothly and that could create a lot of problems in the future," she says.

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Tailor training to role of CM in your hospital

Give new hires time to learn their jobs

There's no "one size fits all" for case management training, which means that hospitals need to create their own training and orientation process based on the specific responsibilities of the department, says **Beverly Cunningham**, RN, MS, vice president of resource management at Medical City Dallas Hospital. What is covered will vary from hospital to hospital, depending on the role of case management, she adds.

The first step is for case management directors to redefine the department's policies and procedures that tell line by line what case managers should know and what they will be held accountable for, then develop job descriptions that fit with the policies and procedures. "The policies and procedures and job descriptions should be structured so that managers can use them during the annual evaluations for their staff," says **Peggy Rossi**, BSN, MPA, CCM, a retired hospital case management director who now is a consultant for the Center for Case Management.

Start by developing a flow chart of the key processes in your department so you understand what they are, Cunningham says. Make a list of all the tasks case managers do in your hospital and make sure new case managers are trained on each and can demonstrate competency.

Create an orientation book so case managers know what is expected of them, have something they can study, and have something to go back to and review what they were taught, Cunningham says. The orientation book should be based on the functions of case managers at your facility and could include care coordination, discharge planning, utilization management, and resources management as well as compliance, Cunningham suggests. Use the case management structure at your particular hospital as a guide and add in hospital and department policies and procedures.

"It's important to have an orientation plan and key people doing the orientation and mentoring who are giving the same message to every person," Cunningham says.

Case management training takes at least four weeks of full-time training that includes listening to people from the various departments talk about how the case manager's role fits into what their department does, Rossi says.

Include the chief operating officer, the chief nursing officer, and the chief financial officer to talk about their roles and how they intertwine with case management. "It's extremely important for new staff to hear from the chief financial officer about the revenue cycle since case management can have such a big effect on reimbursement," she says.

One-on-one training

One-on-one training is the best way, Cunningham says. "Most hospitals don't have the luxury of having a person whose only job is orientation. The person doing the orientation might carry a caseload when there's no one to train or might be a team lead," she adds.

The case management educator should be someone with expertise who can communicate well and who has the ability to let case managers do things on their own while he or she stands back and watches. "You pay in the long run if you don't have a good person doing the orientation and training," Cunningham says.

Rossi suggest that case management clinical educators have extensive knowledge of the case management role. "Orientation for case managers must be more than the general information given to new nurses by the nursing administration. Case managers need to have specific information that nurses don't need, such as Medicare and Medicaid rules and regulations, medical necessity criteria, and the revenue cycle," she says. If the educator comes from outside the system, he or she should be employed in your case management department for at least six months, she adds.

When they are not training new case managers, the clinical educators should set up specific training for the staff on new rules and regulations. "Things are changing so fast in healthcare that six months from now, we may be doing things very differently," Rossi says. The educators need to keep up with the various Medicare, Medicaid, and commercial insurance auditors, what they are looking at, and making sure that the processes and procedures within the department are current and that the staff have current knowledge, she adds. ■

Choose your new case managers carefully

Make sure they fit in your department

If you hire the wrong person for a case management job, you're at a disadvantage from the start, says **Beverly Cunningham**, RN, MS, vice president of resource management at Medical City Dallas Hospital. "You can teach case management, but you can't teach the personal characteristics it takes to be a good case manager," she adds.

Good case managers need to be flexible and not afraid to have uncomfortable but crucial conversations with patients, family members, and sometimes other providers. They need critical thinking skills and the ability to be creative and think outside the box, adds **Peggy Rossi**, BSN, MPA, CCM, a retired hospital case management director who now is a consultant for the Center for Case Management.

She advises case management directors to take their time during the hiring process. Don't look to fill the position. Look to fill the position with the right person, she says.

Look at the personality of case management candidates to see if they fit into the culture of your hospital. Assess their knowledge of the case management process. Recognize that it might be difficult to find someone with the knowledge and skills you need, and that's where the orientation process comes in, Cunningham says.

"Case management directors may not necessarily want to hire an experienced case manager who can hit the ground running. That ground might not be the ground they want them to be standing on," adds **Catherine M. Mullahy**, RN, BSN, CCRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY, case management consulting firm. Sometimes case managers from another organization find it hard to adjust to how their new department operates or bring in bad habits from the other organization. "It may be better to take someone who is not experienced in case management and teach them what they need to know to work in your department," she says.

Make your staff part of the interview process and solicit their feedback. At Medical City Dallas Hospital, case management candidates meet with a team of four case managers, four social workers, or both case managers and social workers, depending on where the person will be assigned. "We want to make sure that the new hire will fit into the team. The staff often asks a question I wouldn't think of asking. I value their input, but the director makes the final decision," Cunningham says.

Floor nurses can become effective case managers but only if they understand the job description and realize that case management is not a hands-on job, Rossi says. Sometimes floor nurses may think they want to be case managers but they don't know what case managers really do and are easily disenchanted with the job, Mullahy says."The role of a case manager is very different from the role of a floor nurse and requires different skills," she adds. Make sure the case management candidates know what the job entails. Consider allowing nurses who want to be case managers to follow along with someone for a day or longer and find out what goes on in a case manager's day, Mullahy says.

Case management directors need to assess case management candidates to make sure they will be good case managers. "Someone may be a great emergency department nurse but isn't comfortable reaching out to families or working with organizations outside the hospital," Mullahy says.

Match the candidate's clinical knowledge to the area to which the new case manager will be assigned, Cunningham suggests. "Case management today is very specialized and requires specialized knowledge. It would not be a good idea to put someone in the ICU who has never worked in the ICU," she says.

The best case managers are those for whom the position is more than just a job, Mullahy says. "You can give case managers computers and software that will help them do their job, but nothing can replace intellectual curiosity and a caring heart," she says. ■

CM training includes education, preceptor

Complex role takes time to learn

At UPMC, an integrated healthcare system with headquarters in Pittsburgh, new case managers spend time on the floor observing a case manager, go through classroom training, then work with a preceptor before going out on their own.

"The role of a case manager is so complex that

it takes a long time for a new case manager to become competent. As a large health system with 15 hospitals, we have developed multiple ways to give new case managers the information and the skills they need to do the job," says **Susan M. Almes**, RN, BS, ACM, training specialist and a former case manager who is certified in InterQual criteria.

The new case managers typically spend one to four weeks in the hospital where they will work, observing and working with an experienced case manager, undergo eight days of intensive training in case management, then spend an additional six weeks with a preceptor back in the hospital.

The time period and content of the initial training for case managers varies from hospital to hospital but is designed to give new case managers a taste of what the job entails and open their eyes to what daily life is like for a case manager, Almes says.

"If they come straight to our training class, it is overwhelming. It's better for them to first spend time on the floor to see firsthand how case managers interact with physicians, how they complete an assessment, how to make payer calls, and other day-to-day tasks," she says.

The health system has a care management training department staffed by a project manager and four former case managers who undergo annual certification in InterQual. In addition to providing the monthly training sessions for new case managers, the department produces webinars and holds lunch-and-learn sessions at individual hospitals to keep case managers up to date on new rules and regulations and InterQual criteria. All case managers must pass annual competencies on discharge planning and the financial aspects of case management.

The classes for new case managers are held monthly for seven hours a day for eight days and are attended by an average of five or six new case managers. Topics include how and when to make payer calls, financial information, how to review a chart for medical necessity, all types of discharge planning, how to work with other departments such as social work, physical therapy, occupational therapy, the medical director, and when and how to request a secondary review of a case. The new case managers spend an entire day on InterQual criteria and must pass a competency test. They undergo extensive training on the health system's case management software and post-acute referral software.

The training includes classroom instruction, including PowerPoint presentations and hand-outs, and scenarios of cases that allow the attendees to practice what they have learned each day. The entire last day of class is spent on scenarios, which include new admission documentation, readmission reviews, application of criteria, and creating a discharge plan. The slides and other hand-outs are included in a book that the new case managers take with them and can consult whenever they have questions.

The new case managers go back to their facility and work with a preceptor for as long as needed. A member of the training staff follows up about six weeks later and spends a day with the new case managers as they do their job. "We can answer questions and help them with areas they are struggling with. Sometimes we are called out earlier if the case manager director feels someone needs one-on-one training early on," she says.

The case management director at the individual facilities decides when the new case managers are ready to go out on their own. "Case management is so rewarding, but it's also so complex and demanding that it takes about six months for a new case manager to feel comfortable in the role and about a year before they feel like they really get it," Almes says. ■

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At UPMC, new case managers initially spend one to four weeks on the floor, following a case manager, then go through intensive training before spending an additional six week with a preceptor in the hospital to which they are assigned.

- Initial time in the hospital gives new case managers an idea about what the job entails, making it easier for them to understand the information they are taught during the training, which includes classroom instruction and demonstrating what they have learned.
- UPMC has a full-time training department staffed by former case managers who are certified in InterQual criteria and also keep the entire case management staff in the health system up to date on compliance issues and new regulations.
- After the new candidates have completed six weeks of working with a preceptor, a trainer spends a day with them to make sure they understand the job and answer any questions.

Proposed rule clarifies admission policies

CMS beefs up quality programs

In the Inpatient Prospective Payment System proposed rule for fiscal 2014, the Centers for Medicare & Medicaid Services (CMS) clarified its long-standing policy on how Medicare contractors review inpatient admissions for payment purposes and continued its emphasis on basing reimbursement on quality.

CMS proposes implementing a new Hospital-Acquired Condition Reduction Program that would penalize the lowest-performing hospitals and expanding the readmission reduction program and value-based purchasing program. *(For more about the proposed quality initiatives, see related article on page 96.)*

The most sweeping change proposed by CMS is to revise medical review criteria to presume that inpatient status is appropriate if there is a physician order and the patient receives care over the span of at least two midnights. Admissions of fewer than two midnights will be presumed to be inappropriate for payment under Medicare Part A unless there is documentation in the medical record that the admitting physician believed that the patient would need care for at least two midnights and an unforeseen circumstance resulted in a shorter stay than the physician expected.

If the proposed rule goes into effect, the inpatient stay would begin when the patient is in an inpatient bed, not when the admission order is issued, and only a physician or other practitioner licensed by the state to admit patients to the hospital would be able to issue the order.

CMS says it has proposed the change to provide guidance on inpatient admissions because of an ongoing concern about the number of patients receiving observation, because hospitals are uncertain about Medicare reimbursement if the patients are admitted.

On the surface, the rule seems clear that when patients stay over two midnights and there is an order to admit from a physician, the hospital stay will be presumed to qualify as an inpatient admission and that shorter stays (fewer than two midnights) will be presumed to be outpatient stays.

"The challenge is in the definition of the word 'presumption.' What does 'presumption' really mean? My interpretation is that the Recovery Auditors [RAs] and other Medicare auditors will continue to focus on inpatient stays of 0 and 1 day and will expand their scrutiny to two and three day stays," says **Ralph Wuebker**, MD, MBA, chief medical officer for Executive Health Resources, a Newton Square, PA, physician advisor company.

CMS also proposes that the inpatient stay will begin at the time that the patient is moved to the bed in the hospital in which he or she will receive care, not at the time the order is written as now is the case, adds **Deborah Hale**, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, a healthcare consulting firm based in Shawnee, OK. It doesn't count the time that patients may stay in the emergency department receiving treatment and waiting for a bed. "If this rule is enacted, it means that patients and the hospitals will be financially penalized when the hospital is at capacity. In the past, CMS has said that inpatient care doesn't mean care in a specific geographic location," she says.

The proposal also could have implications for patients who require a skilled nursing stay, Wuebker points out. The proposed rule doesn't discuss the net effect on the three-day stay mandate for a skilled nursing stay to be covered under Medicare, he adds. "If a patient starts out as an outpatient and is converted to inpatient, it could have a big impact," he says. In addition, patients who are admitted in the evening but don't get into a bed until after midnight could also lose their eligibility for a skilled nursing

EXECUTIVE SUMMARY

In the Inpatient Prospective Payment System proposed rule for fiscal 2014, the Centers for Medicare & Medicaid Services (CMS) has proposed changes to how auditors review inpatient admission and announced plans for basing reimbursement on additional quality measures.

- CMS proposes that auditors should presume that inpatient status is appropriate if there is a physician order and the stay spans two midnights.
- The agency proposes penalizing hospitals for excess hospital-acquired conditions, adding chronic obstructive pulmonary disease and total hip and knee replacements to the readmission reduction program, and announced that it is considering adding a measure to value-based purchasing in fiscal 2017 that assesses a hospital's performance in treating Medicare patients appropriately as inpatients or outpatients.
- The Recovery Auditors and other Medicare contractors will continue to scrutinize medical records and are likely to shift their emphasis to 0-to-3-day stays.

stay, he says.

The rule also could have the potential effect of artificially pushing the payment system in a way that could have adverse financial implications for hospitals, Wuebker says. For instance, currently there are some one-day stays and two-day stays that are appropriate for an inpatient admission. "The DRG system is set up so that some patients in the same DRG stay one day while others may stay three or four days and it all evens out in the DRG payment. The proposed rule appears to remove short stays from the equation without modifying the DRG payment," he says. ■

Proposed IPPS rule focuses on quality

New diagnoses are targeted

The continuing shift toward basing hospital reimbursement on quality emphasized by the Centers for Medicare & Medicaid Services in the Inpatient Prospective Payment System (IPPS) proposed rule for 2014 raises the stakes for hospitals, especially those that treat a lot of Medicare patients.

"The case managers' job is more important than ever as they take the lead in making sure their hospitals score well and don't lose reimbursement," says **Susan Wallace**, MEd, RHIA, CCS, CDIP, CCDS, director of compliance/inpatient consultant for Administrative Consultant Service, a healthcare consulting firm based in Shawnee, OK.

In the proposed rule, CMS announced new diagnoses being targeted in its readmissions reduction program and Value-Based Purchasing Program and announced a new program to impose financial penalties on hospitals that perform poorly on the new Hospital-Acquired Conditions Reduction Program, beginning in fiscal 2015.

The penalties are rising in all of the CMS quality programs, Wallace points out. By October 2014, when the Hospital-Acquired Conditions Reduction Program goes into effect, hospitals stand to lose as much as 3% of their base operating MS-DRG payment in the readmission reduction program, up to 1.5% in the Value-Based Purchasing Program, and 1% in the Hospital-Acquired Conditions Reduction Program.

The new Hospital-Acquired Conditions Reduction program will begin in 2015, and hospitals that rank in the lowest 25% will receive a 1% reduction in the base operating MS-DRG payment. "The program is in addition to the current hospital-acquired conditions program, which does not pay for treatment for certain hospital-acquired conditions and does not replace that program," Wallace says.

In the first year of the Hospital-Acquired Conditions Reduction Program, CMS proposes to score hospitals on six patient safety indicators (pressure ulcer rate, volume of foreign objects left in the body, iatrogenic pneumothorax rate, postoperative physiologic and metabolic derangement rate, post-operative pulmonary embolism or deep vein thrombosis rate, and accidental puncture and laceration rate) and two healthcare-associated infection measures—central line-associated bloodstream infections and catheter-associated urinary tract infections. When scores are calculated, risk factors such as patient age, gender, and comorbidities and complications will be taken into account so as not to unfairly penalize hospitals that care for sicker patients.

"Since the results are risk adjusted, it is important for the record to include complete patient demographic information, and for physician documentation to clearly and completely identify comorbidities," Wallace says.

Maximum reduction in the readmission reduction program will rise to 2% beginning in October 2013. CMS proposes to revise its methodology for calculating penalties to take planned readmissions for heart failure, acute myocardial infarction, and pneumonia into account. The agency proposes to add two new measures beginning in fiscal 2014—readmissions for elective hip and knee arthroplasty and chronic obstructive pulmonary disease (COPD), which applies to patients with a principal diagnosis, or acute respiratory failure as a principal diagnosis with a secondary diagnosis of COPD.

CMS announced new discharge status codes that indicate a planned acute care hospital readmission. For example, one code specifies discharged to home and self care with a planned acute care inpatient readmission. "It's really important for the discharge documentation to be clear when there is a plan for the patient to come back as an inpatient," Wallace says. One example is a patient who is discharged after an acute myocardial infarction who is scheduled to come back for a coronary artery bypass grafting procedure, she adds.

In the proposed rule, CMS announced that it has developed an expanded algorithm to identify planned readmissions and plans to apply it in fiscal 2014 but does not yet plan to use the discharge status codes to distinguish between planned readmissions and

unplanned readmissions, Wallace says.

CMS announced that it is considering adding a measure to value-based purchasing in fiscal 2017 that assesses a hospital's performance in treating Medicare patients appropriately as inpatients or outpatients. ■

Continue focusing on documentation, status

CMs are needed more than ever

The Centers for Medicare & Medicaid Services' (CMS) proposed rule for the 2014 Inpatient Prospective Payment System (IPPS) is subject to change, but hospital case managers still should familiarize themselves with the rule and determine the impact, says **Ralph Wuebker**, MD, MBA, chief medical officer for Executive Health Resources, a Newton Square, PA, physician advisor company.

The proposed rule makes clear and concise documentation and patient throughput more important than ever, he adds.

After the proposed rule was issued April 26, CMS took comments from the healthcare industry until June 25 and will issue the final rule by August 1. "This rule isn't final yet. There are a lot of pieces in the proposed rule every year that don't get into the final rule when it is issued in August," Wuebker says. *(For details on the proposed rule, see related articles on pages 95 and 96.)*

Case managers should do what they always have done and focus on making sure the documentation accurately and completely represents the reason for admission, especially when there are extenuating circumstances, such as failed outpatient management, factors that increase the risk for the patient, and the availability of diagnostic services at the time the patient comes into the hospital, says **Deborah Hale**, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, a healthcare consulting firm based in Shawnee, OK.

"CMS is harping on the necessity for an admission order that clearly documents the reason for the admission and requires that the order be issued by a physician or other medical professional licensed to admit patients to the hospital. In cases where it's blatantly obvious that a patient needs to be admitted, the physician documentation might not be that important. When there is any doubt, physicians should explain what they were thinking in the medical record," she says.

CMS make it clear that only the physician can determine if patients need to be admitted or be in outpatient status receiving observation services, says **Joanna Malcolm**, RN, CCM, BSN, consulting manager, clinical advisory services for Pershing, Yoakley & Associates in Atlanta. "It appears that if there is not an order from the physician and the physician documentation doesn't specify inpatient status that CMS is going to deny payment," she says. Physicians no longer will be able to write "status by case management protocol," she says.

Despite CMS' presumption that a stay spanning two midnights is appropriate for an inpatient admission, Medicare auditors will still review records for medical necessity, which means that case managers must make sure the documentation in the medical record justifies an inpatient admission and discuss the criteria with the physician, Malcolm adds.

Case managers should be educating physicians about medical necessity criteria and what the Medicare auditors are looking for.

If the proposed rule goes into effect, hospitals are going to be tempted to keep all patients who are expected to have a stay of less than 48 hours as outpatients with observation services, but some short stays meet the criteria for an inpatient admission, Hale says. "This creates issues because this rule focuses just on inpatients and doesn't include information as to whether outpatient reimbursement will be increased. The average observation payment is about $400 [excluding emergency department charges]. This doesn't cover a 48-hour stay," she says.

If hospitals automatically keep patients who have a 48-hour or shorter stay as outpatients receiving observation services, it can have financial implications for patients who have to pay co-insurance costs for outpatient services, Hale points out. In addition, Medicare rules say that patients receiving care as outpatients are also responsible for payment of self-administered drugs, which can be more than their inpatient deductible, Hale says. "This can be very expensive for some patients, such as those who need anticoagulation. Even if the nurse administers the medication, it's considered a self-administered drug," she says.

The proposed rule creates an increased focus on medical necessity and risk assessment by the attending physician, Wuebker says. "Documentation is key. Often we will see a one-symptom-based diagnosis. The medical record needs to include more of the physician's thoughts during the decision-making process," he adds.

Case managers should work with the attending

physicians to improve medical necessity documentation and continue to perform the utilization management review to make sure the documentation supports the level of care, Wuebker says.

Patient throughput is going to become extremely important if that provision goes into effect, Wuebker says.

"In most hospitals, the majority of patients are admitted between 5 p.m. and 11 p.m. If the admitting order is signed at 10 p.m. but the patient doesn't get into a bed until 1 a.m., you've lost a midnight," he says. ■

Group seeks the root cause of readmissions

Interventions keep patients out of the hospital

Faced with high readmission rates and patients who made multiple visits to the emergency department and were hospitalized frequently, a multidisciplinary team at Lehigh Valley Health Network began analyzing the cases of frequent utilizers one at a time, getting to the root cause of the readmissions, and developing a plan to keep them out of the hospital and emergency department.

The High Utilizers Group (HUG) team began meeting in the fall of 2011. "We don't currently have any hard data to report but we are working on development of a standard process to collect data. We do know that in many cases, we've made a huge difference," says **Maureen Sawyer**, MSW, LSW, ACM, director of case management for the three-hospital system with headquarters in Allentown, PA.

Initially, the team reviewed the cases of the top 36 patients who made frequent use of the emergency department and had numerous short inpatient stays, looking for patterns in readmissions. "We found interesting tidbits, but we didn't determine any one thing we could do to make the problem go away," Sawyer says. Participants in the HUG team included people from across the continuum, including representatives from inpatient hospitals, behavioral health, home health, and palliative care to collaborate on solutions. "We did a lot of talking, but we didn't get that far until we brought in the line staff people who work directly with the patients," Sawyer says.

The expanded committee includes emergency department case managers, inpatient case managers, transition coaches, pharmacists, home health social workers, payer representatives, and representatives from the county mental health department and Area Agency on Aging offices.

"With that mix, we had people who were close to what was going on with the patients and could identify the real barriers to care. We got very personal and discussed each individual in depth to determine what they needed. We stopped rolling our eyes and assuming that frequent utilizers are noncompliant, and we have begun drilling down to find the root causes of the utilization," she says.

As the group continued to meet, several physicians have joined and provided medical background that the rest of the team doesn't always have. "These physicians are willing to dedicate a lot of time to the cases. They don't just come to the meetings; they prepare by reading the charts to determine the prior treatment and are able to give advice about consultations or changes in the treatment plan," she says.

Physicians who participate include a gerontologist who consults with skilled nursing facilities; a hospitalist who treats a lot of the patients being discussed; the medical director for home care and the system's short-term skilled facility; and the president of the medical staff, who is a family practice physician in the community.

The team meets for an hour twice a month and discusses two to four cases. The team started working off the list of the 36 highest utilizers. Now the team sends an e-mail before the meetings to a wide variety of clinicians throughout the continuum asking if they have a case they would like to discuss. "Often, we don't have to ask. Someone has a patient they are concerned about and asks to be put on the agenda," Sawyer says. Many times, more than one person on the team is familiar with the patient being discussed and has been frustrated with lack of progress.

The group discusses each situation and comes up with a recommended care plan that one team member shares with the people who are working with the patient. "It works very well when the patient is in the hospital and we get information back to the treatment team. After patients are discharged, we go through the primary care provider office," she says.

One challenge to the collaboration is that some team members use different computer systems, although the hospital system is in the process of merging the information technology across the system. "But when we sit around the table, we can swap computers and see the documentation for inpatient care, home care, and other providers. It helps us pull everything together," Sawyer says.

The meetings have developed a strong connection between the inpatient setting and behavioral health, Sawyer says. "They historically operate in two differ-

ent worlds, but now they share information and participants bring the information back to their areas," she says.

The team developed a simple template that presenters fill out before the meeting. Information includes name, age, brief medical history, number of admissions and emergency department visits, community services received, and the patient's primary care physician.

Many of the patients are referred to palliative care or connected with behavioral health services.

"A lot of the time, we refer patients to our palliative care team to discuss the goals of treatment with patients and families to identify the patients' wishes. A high percentage of patients have a behavioral health comorbidity that causes them to struggle with their complex medical conditions. In these cases, we get them reconnected with a behavioral health provider who can help them," she says.

It's not unusual for patients to be a topic of discussion several times over the course of a year.

Sometimes, it's a matter of the patient seeing their primary care provider for follow up after an emergency department visit. Some patients go to the emergency department and leave with a month's supply of pain medication, then go back to the emergency department when that runs out. "We make sure they have an appointment with their doctor and make sure they are following up, and then alert the emergency department to make sure they're not enabling the patient," Sawyer adds.

The team looks for successes in small increments, Sawyer says. "One of the things we learned early on was to lower our expectations. We wanted to keep the patients from coming back, but we realized that if someone was coming in weekly and we were able to get it down to every six weeks, we were helping everybody, and especially the patients," she adds. ■

Case study shows program's success

When members of the multidisciplinary High Utilizers Group (HUG) team at Lehigh Valley Health System in Allentown, PA, began analyzing the case of the individual who topped the list of high utilizers, they realized that everybody on the team had worked with him in one capacity or another.

The patient had been in and out of the hospital frequently and had made multiple visits to the emergency department. "When we looked at everything that was going on with this patient, we determined that he had experienced multiple losses. His mother died, he was going through a divorce, and he had lost his job," says **Maureen Sawyer**, MSW, LSW, ACM, director of case management for the three-hospital system.

Multiple people had tried to reach out to him and engage him in following his treatment plan but had been unsuccessful. "Nobody had been able to develop a close relationship. When he came to the emergency department, he was treated by a different person every time. He didn't always have the same caregivers on the inpatient unit," Sawyer says.

A home health nurse on the team who was trained in behavioral health and crisis intervention had worked with the patient in the past and had a mostly positive relationship. The nurse started visiting the patient when he came into the emergency department and on the inpatient unit and following up at home. In the beginning, the patient didn't answer the telephone or the doorbell, but the nurse finally was able to gain his trust and get him to participate in therapy in the home setting. The patient's visits to the emergency department and hospitalizations are less frequent now. ■

CNE OBJECTIVES

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

- identify the particular clinical, administrative or regulatory issues related to the profession of case management
- describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the healthcare industry at large
- discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

COMING IN FUTURE MONTHS

- What should the role of case managers be?
- Why daily huddles are so important
- Discharge planning for the uninsured
- Are your staff culturally competent?

CNE QUESTIONS

1. According to Peggy Rossi, BSN, MPA, CCM, a consultant for the Center for Case Management, how long should case management training take?
   A. A minimum of four to six weeks.
   B. At least a week with a preceptor.
   C. At least six weeks of classroom training.
   D. A minimum of two weeks for experienced case managers.
2. According to Susan M. Almes, RN, BS, a former case manager, now a training specialist for UPMC how long does it typically take for a new case manager to feel comfortable in the role.
   A. One year.
   B. Six months.
   C. Six weeks.
   D. Four weeks.
3. In the Inpatient Prospective Payment System Proposed Rule for Fiscal 2014, the Centers for Medicare & Medicaid Services (CMS) announced plans to add readmissions for elective hip and knee arthroplasty and chronic obstructive pulmonary disease as principal diagnosis, or acute respiratory failure as a principal diagnosis with a secondary diagnosis of COPD to the Readmissions Reduction Program.
   A. True
   B. False
4. The High Utilizers Group (HUG) at Lehigh Valley Health Network in Allentown, PA, meets for an hour twice a month to discuss patients with frequent admissions or emergency department visits. How many patients do they typically discuss in an hour?
   A. Six or more.
   B. Five to 10.
   C. Two to four.
   D. One or two.

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