HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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Confusion ahead as CMS changes inpatient criteria

Two midnights is now benchmark for a stay

The Inpatient Prospective Payment System (IPPS) final rule for fiscal 2014 makes it more important than ever for case managers to develop a close working relationship with physicians and to review every admission to ensure that the documentation is complete and meets the requirements in the rule, says **Linda Sallee**, MS, RN, CMAC, ACM, IQCI, director for Huron Healthcare with headquarters in Chicago.

In the final rule, the Centers for Medicare & Medicaid Services (CMS) establishes a benchmark of two midnights for an appropriate inpatient admission and sets out a series of documentation requirements to support the admission. The rule emphasizes the need for a formal, written admission order by a physician or another practitioner who has admitting privileges in the hospital and mandates that the medical record must include the reasons the physician believes the patient should be admitted, the anticipated length of stay, and the plan of care, Sallee adds.

EXECUTIVE SUMMARY

In the Inpatient Prospective Payment System final rule for 2014, the Centers for Medicare & Medicaid Services established a benchmark of two midnights for an inpatient admission and issued robust requirements for documentation.

- Case managers must work closely with physicians to ensure that the documentation includes the expected length of stay, the rationale for hospital treatment, the treatment plan, and a written order for admission.
- Case managers must review every admission within 24 hours to make sure the hospital doesn't lose reimbursement.
- Auditors will be looking for incidents where hospitals keep patients over two midnights when it's not medically necessary in order to get inpatient reimbursement.
- CMS continues to emphasize quality in care.

Admissions on or after Oct. 1, 2013, are affected by the rule.

Patients should be admitted as inpatients if physicians expect the length of stay to span two midnights based on medical factors, such as patient history, comorbidities, the severity of signs and symptoms, and risk of adverse events, she adds. The physician documentation must certify that the services the patient requires must be provided on an inpatient basis. There are some exceptions to the rule. Procedures on the inpatient-only list are exempt from the two-midnight rule as are incidents when patients leave against medical advice, die, or are transferred to another facility, Sallee says.

Physicians can take the time patients have spent being treated as outpatients into consideration when they apply the two-midnight benchmark, says **Adele Merenstein**, JD, an attorney at Hall Render, a law firm specializing in health law with headquarters in Indianapolis. However, the time before the formal order is written cannot be counted as inpatient care to make the patient eligible for a skilled nursing stay, she adds.

The final rule doesn't eliminate instances when a one-day inpatient stay is medically necessary, says **Ralph Wuebker**, MD, MBA, chief medical officer for Executive Health Resources, a Newtown Square, PA, healthcare consulting firm. "There are always going to be patients who recover more quickly than expected or than normal according to standards of care. In those cases, the documentation in the medical record must clearly show 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," he says.

In the short term, hospitals need to set up a triage team to develop a process to make sure the medical record contains all of the elements required by the final rule, including an order, the expected length of stay, and the documentation that supports the physician's decision to admit the patient, says **Brian Flood**, CHC, CIG, AHFI, CFS, an attorney specializing in healthcare issues and partner with Brown McCarroll, LLP, in Austin, TX. "Case managers immediately should begin to work with physicians to improve documentation," Flood says. "Once physicians make the decision to admit patients, they have to put it in writing and document the reason and the expected length of stay," he says.

The best way for hospitals to make sure that admissions are appropriate and the medical record contains the required documentation is to have case managers in the emergency department reviewing patient admissions, Sallee says. "Once patients get in a bed, it gets harder to make sure they are in the proper status. It's more important

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than ever for case managers to see every patient in person within 24 hours of admission. Case managers should be reviewing 100% of Medicare cases and getting them 100% correct before discharge, she says.

CMS says the final rule is intended to provide additional guidance as to when patients are appropriately treated and how hospitals are reimbursed for inpatient care as well as helping patients who in recent years have been receiving lengthy observation services when an inpatient admission may have been medically justifiable, Merenstein says.

"In recent years, physicians have been hesitant to order an inpatient admission early in the patient's episode of care for fear of a costly inpatient admission denial. The beneficiaries may have incurred greater financial liability in the form of Medicare Part B copayments, charges for self-administered drugs, and in some cases, charges for post-hospital skilled nursing facility care," she adds.

CMS stated its intentions to make the inpatient versus outpatient question clearer but the IPPS final rule makes is more complicated, Flood says. The Centers for Medicare & Medicaid Services intends to issue guidance to providers and auditors on how to implement the inpatient admission guidelines, but that could take six months or longer, Flood points out. In the meantime, hospitals will struggle to make sure they are in compliance with the final rule, he adds.

"To say the rule is confusing would be an understatement. It puts traditional, relied-upon guidance on its head and ignores decades of experience basing admissions on InterQual and Milliman guidance," he says. Instead of relying on medical necessity criteria, physicians are being asked to base the decision to admit on the expected length of stay, he adds.

In an Open Door Forum on the two-day rule, CMS officials pointed out that InterQual and Milliman criteria sets have always been tools to guide hospitals but have never been Medicare policy.

Case managers still need to use InterQual and Milliman to assist physicians regarding needed documentation and to make sure patients meet criteria for continuing stays, Sallee adds.

Wuebker emphasizes that the two-midnight rule in no way substitutes for the utilization review process. "Case managers still need to review the charts, make sure that there are admission orders and sufficient and appropriate documentation in the medical record to support the physician's judgment to admit the patient or order observation services," he says.

Case managers will still have the flexibility to use Condition Code 44 to change inpatient to outpatient if a review determines that patients don't meet inpatient criteria, she says. But it's still better to get the majority of cases right up front, Sallee says.

The final rule includes two distinct two-midnight policies in the final rule, according to Merenstein. One is the two-midnight benchmark which gives guidance to admitting physicians and reviewers when determining whether it is appropriate to admit on an inpatient basis. The other is the two-midnight presumption which states that claims for inpatient services with a length of stay spanning two midnights after an admission order will generally be presumed to be appropriate for payment under Medicare Part A, she says.

The rule states that an external review contractor, such as a Recovery Auditor (RA) or Medicare Administrative Contractor (MAC) should presume that an inpatient hospital admission is reasonable and necessary if the patient requires a stay that spans two midnights and receives medically necessary services, including surgical procedures or diagnostic tests after the inpatient admission, she adds.

CMS is asking physicians to look forward and determine if the patient is expected to stay in the hospital for two midnights and if so, order an inpatient admission, Wuebker points out. At the same time, CMS says that when auditors look on the back end of the process, if patients are in the hospital for two midnights, the auditors should presume that the case is appropriate for inpatient admissions, if adequate documentation is in place, Wuebker says.

CMS is requiring the auditors to look at the entire chart from the beginning, rather than after the inpatient order, Wuebker says. "This is a big victory for hospitals because it eliminates penalties for hospitals when there are artificial one-midnight stays," he adds. For instance, a physician orders observation services for a patient at 9 p.m., but when the case manager reviews the case the next morning, it is determined that the patient meets inpatient criteria; then, the patient stays another night. In the past, by looking at the claims data, an auditor might conclude that the patient was in the hospital just one midnight and deny

the case when in fact he or she was in the hospital receiving treatment for two midnights and inpatient is appropriate.

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Documentation is the key to getting paid

Make sure record is complete

As the Medicare Inpatient Prospective Payment System (IPPS) final rule goes into effect, the biggest struggle for hospitals, physicians, and case managers will be providing thorough documentation in order to ensure that hospitals receive their proper reimbursement, says **Ralph Wuebker**, MD, MBA, chief medical officer for Executive Health Resources, a Newtown Square, PA, healthcare consulting firm.

The final rule requires physicians to state how many days they expect the patient to be in the hospital, the rationale for in-hospital care and the plan of treatment, Wuebker says.

"The documentation doesn't have to be an elaborate four-page history and physical. Frequently, the necessary documentation can be accomplished with just three or four sentences. Unfortunately, we see a lot of documentation that is just one or two words, and that will not be sufficient. Improving that kind of documentation is going to be the challenge for case managers," he says.

At best, physicians typically include patient history and general findings in the documentation but rarely write out a plan of care and never include the expected length of stay, adds **Linda Sallee**, MS, RN, CMAC, ACM, IQCI, director, for Huron Healthcare with headquarters in Chicago. "In some cases, the information needed for medical necessity is in the physician's office and not the chart. Case managers are going to have to work closely with physicians to make sure the documentation reflects that patients need care in the hospital, rather than being treated and sent home," she says.

For instance, physicians have sometimes admitted frail elderly dementia patients for three days so they qualify for a nursing home stay. "Some of these patients don't need inpatient treatment or even observation services. They need to be treated as outpatients and sent home," she says.

Under the final rule, physician documentation is expected to include what is wrong with the patients that indicate they need care in the hospital, including severity of illness and intensity of service. It must include the plan of care and the expected length of stay.

"This is a huge turn of events for physicians. Some write very little in the chart. This is why case managers need to see every patient in person in addition to reviewing the chart and make sure that the patient's actual condition and services received match what is in the chart," she says.

In order for the hospital to bill Medicare, the documentation has to certify that the patients need to be in the hospital, Sallee points out. Physicians need to make a list of the reasons patients require care in the hospital or write the reasons out as a narrative, she adds.

Case managers should see every patient in person within 24 hours of admission and make sure the patient's condition and treatment are documented in the chart, then call the physician if what they see isn't reflected in the chart, she suggests. "Physicians must be very thorough and document the condition completely. Case managers can't simply call a physician and say a patient doesn't meet criteria. They must ensure that the physician is very specific about the patient's condition and be sure that it is accurately reflected in the chart, in turn, to justify and explain the inpatient stay," she says.

As you work with physicians, help them to document the case as accurately as possible in accordance with the final rule, Wuebker says. Ask them to include their medical rationale and not just the treatment plan. Adding this piece will ensure documentation is clear if the case does get selected for audit. In addition, make sure there is an order for admission. Ask the physicians to "think in ink," he says.

"Asking the physicians to get the expected length of stay correct up front is challenging," Wuebker says. Instead of asking physicians if they expect patients to be in the hospital over two midnights, ask them if they expect that the patients will go home the next day. If they think that the

patient will go home in the morning, the patient should be an outpatient receiving observation services. If not, the patient should be admitted as an inpatient. "This type of question translates the regulations into guidelines physicians can use and understand. And getting the physicians' cooperation begins with understanding," he adds. ■

Don't think the auditors will go away

Chart review remains of utmost importance

The Centers for Medicare & Medicaid Services has declared that a stay spanning two midnights is presumed to be appropriate for an inpatient admission, but Medicare auditors will still be reviewing records for medical necessity.

Medicare auditors are likely to continue to look at one-day stays and will take a close look at two-day and three-day stays and the issue of qualifying stays for a skilled nursing transfer, says **Brian Flood**, CHC, CIG, AHFI, CFS, an attorney specializing in healthcare issues and partner with Brown McCarroll, LLP, in Austin, TX.

This means that case managers still must review physician documentation to make sure all of the elements required for an admission are included. Otherwise, they are begging for an audit, he says. "Hospitals that don't have a robust screening process to scrutinize admissions will be subject to losing more money in the future," he says.

Physicians have to do far more documentation than just write "admit" on the chart, Flood points out. If a physician writes "admit" on the chart and doesn't document a reason for the admission, it will be a red flag for auditors, Flood says.

If physicians don't include a prediction of the patient's length of stay in the documentation, it is likely to catch the attention of auditors, but if the patient ended up staying for two midnights and the documentation reflects severity of illness and resources consumed, the hospital can make a good argument in an appeal if the case is denied, he says.

Auditors are likely to continue to focus on DRG validation and coding, particularly as hospitals begin to struggle with meeting the documentation and coding requirements for ICD-10, says **Ralph Wuebker**, MD, MBA, chief medical officer for Executive Health Resources, a Newtown Square, PA, healthcare consulting firm. He also expects auditors to continue the focus on medical necessity, especially instances where patients who are admitted as inpatients stay less than two midnights and to review two and three midnight stays where there is evidence that the hospital may be keeping patients longer than appropriate to receive inpatient reimbursement.

The final rule clearly states that auditors will make sure that hospitals are not gaming the system for inpatient stays, he adds.

In fact, CMS says in the final rule that it will be on the lookout for hospitals that game the system by keeping patients over two midnights when it's not medically necessary in order to get inpatient reimbursement, adds **Adele Merenstein**, JD, an attorney at Hall Render, a law firm specializing in health law with headquarters in Indianapolis. "If hospitals are found to be abusing the two-midnight presumption, CMS auditors will disregard the two-midnight rule when they conduct reviews," she says.

Hospitals are going to be audited if they have a huge increase in three-day stays as the Recovery Auditors and other auditors are likely to focus on whether patients who stayed over three midnights and went to a skilled nursing facility met medical necessity for all three days, says **Linda Sallee**, MS, RN, CMAC, ACM, IQCI, director for Huron Healthcare with headquarters in Chicago.

"Case managers need to make sure that patients continue to meet medical necessity throughout their stay, particularly if they are candidates for a skilled nursing stay," she says. ■

CMS focuses on quality, not quantity in IPPS

Hospitals stand to lose more reimbursement

In the Inpatient Prospective Payment System (IPPS) final rule for 2014, the Centers for Medicare & Medicaid Services (CMS) continues its emphasis on quality and pay for performance.

"CMS is focusing more and more on quality versus quantity. Not only do hospitals need to focus on providing high-quality care, case managers need to work with physicians to make sure that documentation reflects severity of illness and the services the patients received," says **Linda Sallee**, MS, RN, CMAC, ACM, IQCI, direc-

tor for Huron Healthcare with headquarters in Chicago.

In the final rule, issued Aug. 2, 2013, 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.

And the penalties are rising. Penalties in the value-based purchasing program rise to 1.25% in October and go up by 0.25% each year until they top out at 2%. Penalties in the hospital readmission program are rising from 1% to 2% beginning with discharges on Oct. 1, 2013.

In the Hospital Acquired Conditions Reduction Program, which will begin in fiscal 2015, hospitals that rank in the lowest 25th percentile will receive a 1% reduction in the base operating MS-DRG payment. CMS already is not paying for treatment of certain hospital-acquired conditions.

The program gives hospitals scores in two domains of measure sets, taking risk factors such as patient age, gender and comorbidities into account. Measures in Domain 1 are weighted at 35% and include pressure ulcer rate, volume of foreign objects left in body, iatrogenic pneumothorax rate, central venous catheter-related blood stream infection, postoperative hip fracture rate, perioperative hemorrhage or hematoma rate, postoperative physiologic and metabolic derangement rate, postoperative respiratory failure rate, postoperative pulmonary embolism or deep vein thrombosis rate, postoperative sepsis rate, postoperative wound dehiscence rate, and accidental puncture or laceration rate.

Domain 2, which is weighted at 65%, includes central line-associated blood stream infection and catheter-associated urinary tract infections.

In addition, CMS is adding three new diagnoses—chronic obstructive pulmonary disease, elective total knee replacement, and elective total hip replacement—to the readmission reduction program with penalties beginning in fiscal 2015.

CMS is likely to continue to expand the number of diagnoses in the readmission reduction program the future, Sallee says. "This means that hospitals need to look globally at readmissions and not just concentrate on the ones in the program in order to prevent losses in the future," she says.

CMS announced 15 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. The codes apply to all planned readmissions, not just those that occur within 30 days. "Case managers will need to pay more attention to discharge plans and to make sure the documentation indicates it if there is a planned readmission. It's really important that the discharge documentation is clear when there is a plan for the patient to come back as an inpatient," Sallee says. ■

Team focuses on needs of the elderly

Goal is to help seniors maintain independence

By reaching out to community organizations and agencies to collaborate on care management and improve care transitions for its high-risk elderly population, Scottsdale Health System has decreased readmissions and frequent emergency department visits among the area's senior population.

The goal of the initiative is to help seniors get what they need to maintain their independence and maximize their health. "The elderly have a multitude of issues that cause their discharge

EXECUTIVE SUMMARY

Scottsdale Health System has seen a decrease in readmissions and emergency department visits among the elderly since the three-hospital system brought together all the community organizations and agencies to collaborate on improving transitions.

- The organizations began meeting regularly and educating each other on what services they provide, the challenges they face, and the boundaries they must observe.
- They developed a way to share data so each participating entity knows what interventions and services an individual receives from the other organizations.
- The collaboration has improved employee satisfaction among the participants because the staff no longer feel they are operating in silos and are able to get a full picture of what's happening with the senior with whom they are working.

plans to fail and drain the resources from the city on multiple levels. They are fragile, many live alone and are isolated, and they have a lot of fears. They make a lot of calls to 911 and have frequent visits to the emergency department. We are working together to look at these individuals and their living situations and to get to the root causes of their problems," says **Catherine Holdeman**, RN, MSN, system manager for the care coordination program, focusing on patient-centered care and the elderly.

As part of its implementation of patient-centered care initiatives, the three-hospital system brought together all of the community organizations that provide services for the elderly including the fire department, police department, crisis workers, senior centers, the parish nursing program, and adult protective services to talk about how to provide better care for the elderly.

"We wanted to build a strong relationship with other organizations in the community that provide services to the elderly. We understand our population, their chronic diseases, behavioral health issues, and their access to physicians, but we didn't have good communication with some of the agencies that also provide services to our patients," Holdeman says.

Senior citizens have a tremendous number of issues that can cause the discharge plan to fail and send them back to the hospital, points out **Karen Ford**, RN, MSN director of case management. "Every time our process breaks down, the seniors either call 911 or go to the senior center for help," she adds.

When representatives from the various agencies began getting together, it was eye-opening to realize how little all the players were talking to each other. "Sometimes patients would call 911 eight or nine times a month. They'd bring them to the emergency department and we'd treat them and send them home, but since we weren't communicating well, none of us had the full picture," Ford reports.

Representatives from all the agencies work together as a team and collaborate on how to pool the resources of all the entities to benefit the entire community. "The players at the table all have different strengths and different experiences. We all have shared the challenges that our current practices present and are working together to change the way we provide healthcare. We have worked to get the support of leadership from all entities and to determine what we can and can't accomplish," Holdeman says.

During the meetings, representatives from each organization have educated each other on what goes on in their part of the continuum. "Understanding the roles of each organization and the boundaries they must observe takes the mystery out of what everybody does and helps build relationships," Ford adds.

For instance, the other agencies did not initially understand medical necessity criteria, patient status, and other regulations hospitals must follow, such as the three-day rule for Medicare to cover a stay in a skilled nursing facility. "Until we explained it, everybody asks why we couldn't just keep patients for three days until they qualify for a skilled nursing facility stay. Agencies often had the perception that the hospital didn't work in the best interest of the patient and family, and now that they understand the rules we have to follow, they know it isn't the case," she says.

The group started meeting monthly in early 2011 as an executive group. The meetings have evolved into subcommittees working on different areas and with different focuses, Holdeman says. One group includes representatives from the hospital and the fire department who are working on emergency department issues. Another is concentrating on specific issues that individual seniors face.

Each of the organizations has utilization metrics that it tracks, but until recently, the organizations didn't combine their data. Now, for instance, the partners can track how many times an individual has been to the emergency department and how many times he or she has called 911. The senior center can use the information to send a social worker into the community to find out exactly what the senior needs. "It could be something as simple as linking the person with the senior center. Sometimes people call 911 because they just lost their spouse, their family lives out of state, and they feel alone," Ford says. Other times, it may be that the best solution for the person may be in an alternative living setting with more support.

The staff from the senior centers or Adult Protective Services can determine what the individual or family needs, whether it's financial help or setting up Meals on Wheels or housekeeping assistance, and link them with community organizations that can provide services.

In some cases, the staff at a senior center notices that someone who has been coming there regularly is showing signs of dementia or struggling with walking. Then the center's case manager can link the individual with a primary care physician and make sure he or she sees the physician regularly.

"These relationships and communication links are powerful and invaluable to us as we complete our assessments and discharge plans. Patients often come in and we treat whatever is wrong and they come back. We try to find out what is going on with them outside the hospital walls, but many times people, especially the elderly, say everything is fine at home," Ford says. But sometimes the police or fire representatives report that the patient is showings signs of hoarding, the house is a unsafe, there's no food in the refrigerator, or they have behavioral problems, she adds.

"The crisis team sees people in their home and can share a wealth of information, such as living conditions or family dynamics while the individual tells us what they want us to hear. These interactions with other agencies help us put the pieces together," Ford says.

Many times now, when patients come into the emergency department or are admitted, the agency that has been working with them sends the hospital case management department an email asking the inpatient case management team and transitional care services to work with them on the discharge. "Now we are covering all the bases. They may give us information that otherwise we would not have known," she says.

In one case, the first responders to the 911 call noted that there was an eviction notice on a patient's door. "The patient didn't disclose this, and we wouldn't have known if the fire department hadn't put it in the notes. Having this information helped us find an alternative living situation and ensure a healthier transition out of acute care," she says.

The organizations can also intervene when younger, disabled people who consume a lot of resources need assistance, she says. For instance, some people call 911 every night because they need help transferring from a wheelchair to the bed. In these cases, someone from a community agency intervenes to get the person into an assisted living center or set up assistance to help with activities of daily living.

"When everyone talks to each other, it's advantageous to the city, the patients, their families, and the healthcare system. It also has helped employee satisfaction because everyone works collaboratively and addresses the root causes of the problems so employees feel that they have done the best job they can of helping the individual," Holdeman says. ■

ED observation unit targets 24-hour stays

Quick discharges are the norm

An emergency department observation unit targeting patients whose stays are likely to be 24 hours or less has been so successful that Massachusetts General Hospital has opened a second unit.

The hospital opened the first emergency department observation unit, a 13-bed unit on the 12th floor of the hospital, in 2006 as payers began denying short inpatient stays and the emergency department was under pressure to move patients out after state of Massachusetts regulations no longer allowed hospitals to go on diversion, says **Barbara McLaughlin**, RN, BSN, MSM, CCM, case manager on the emergency department observation unit. The second unit, with 18 beds on the hospital's main floor, is called the Short Stay Unit and opened in 2012. Both units use the same criteria for admitting patients and rotate taking patients who qualify.

EXECUTIVE SUMMARY

Faced with denials for short stays and pressure to get patients out of the emergency department, Massachusetts General Hospital established an emergency department observation unit for patients whose stays are likely to be 24 hours or less.

- The emergency department and case management staff compiled a list of diagnoses and complaints that typically result in short stays and target those for transfer to the unit.
- The unit has a dedicated staff that includes nurses, case managers, nurse practitioners, and a physical therapist who evaluates patients each morning.
- The team concentrates on ensuring that patients get the services and evaluations they need to be discharged in 24 hours.

"We worked with the emergency department to develop a strategy to move patients to a dedicated unit that could provide a quicker discharge than the regular medical-surgical units," McLaughlin says.

The emergency department and case management staff compiled a list of diagnoses and complaints that are appropriate for transfer to the observation unit, including syncope, chest pain, vertigo, abdominal pain, and others that typically result in less than a 24-hour stay. The unit is staffed by a dedicated team of nurses, case managers, nurse practitioners, and a dedicated physical therapist who comes on duty early in the morning to evaluate patients.

The hospital set up the 12th floor observation unit on an existing unit that originally had only community bathrooms. "In the beginning, patients had to be ambulatory and not require supervision. We realized this wasn't realistic and installed commodes in some rooms and made sure patients in the other rooms could walk to the bathroom," she says.

Case managers staff the unit from 7:30 a.m. to 6 p.m., seven days a week. The emergency department case managers cover the unit on other hours. "Most of the patients who come in after 6 p.m. are going to need a stress test or other procedures the next morning. If a patient is going to be going to a post-acute facility or go home after the case managers no longer are on the unit, we make sure the ambulance and other patient services are set up before we leave," she says.

When the unit first opened, there was one nurse practitioner who worked all day. "We soon realized that with the morning turnover, most of the patients were discharged by 1 p.m. and a whole new group of patients were coming in," she says. Now one nurse practitioner comes in at 7 a.m. and another begins work at 1 p.m. A third handles new admissions from 7 p.m. to 7 a.m.

When the emergency department staff determine that a patient is appropriate for the unit, an emergency department physician writes the order for the transfer and acts as the attending physician. The nurse practitioner and nurse, along with the case manager and the interdisciplinary team, make an assessment and determine what the patient will need for discharge. Nurse practitioners are responsible for the care on the unit. The case managers review the chart for high-risk patients and set priorities depending on the patient's age, insurance coverage, living situation, ambulatory status, cognitive issues, and barriers to discharge.

"We watch the clock and try to limit the stay to 24 hours. We are focused on moving patients out as soon as it is safe and appropriate. We have rounds every morning when we talk about barriers to discharge and what we can do to get the patients out as soon as possible," McLaughlin says. Tests and procedures for patients on the observation units get priority.

When patients are expected to need post-acute services, McLaughlin lines them up as soon as she finds out. She prepares patients to line up transportation so they will be ready to go when the discharge order is written.

The hospital is participating in a Medicare Demonstration Project to waive the 72-hour required stay for a skilled nursing admission, which makes it possible for the case managers to divert some patients to a skilled nursing facility right from the observation unit. For instance, if a patient had a fall with no broken bones but could benefit from physical therapy but can't be discharged to home, he or she can go directly to a skilled nursing facility.

When a physician decides that patients in the observation unit need to be admitted, the observation unit case managers already have collected information on the patients and started the plan of care. "Even if we can't get them out, we've started the ball rolling for the inpatient case managers," she says.

The emergency department and observation unit nurses and case managers are cross-trained to work in either location if needed. Before the observation unit had dedicated staff, the nurses from the emergency department took turns covering it. "They learned the routine and the kind of patients we take and now can make a suggestion to the physician if they think a patient would qualify for the observation unit," she says.

Communication between the emergency department staff and the observation units is key to the success of the unit, McLaughlin says. "We are in constant contact about patient needs and bed availability. In addition, the case managers from the two observation units and the emergency department meet monthly to discuss cases and ways to improve the process," she says. ■

Leveraging resources improves care for seniors

Program cuts admissions, ED visits

A program that integrates care between the hospital, primary care providers and the community has reduced readmissions and emergency department visits by at-risk low-income seniors served by Wishard-Eskenazi Health, a large safety net health system with headquarters in Indianapolis.

The system includes Wishard Memorial Hospital, a 350-bed facility on the Indiana University Medical Center Campus, 10 community health centers, and a mental health division.

The hospital staff and Indiana University Center for Aging Research investigators developed the Geriatric Resources for Assessment and Care of Elders (GRACE) program because of the need for more geriatric care in the primary care setting, says **Dawn Butler**, MSW, JD, director of the Indiana University GRACE Training and Resource Center based at Wishard-Eskenazi Health.

"Our patient population is getting older, and there is a lack of geriatric care available in the area. We developed this program as a way to take a small geriatric work force to help primary care physicians manage the care of seniors," she says.

In a two-year study, patients who received the GRACE intervention showed significant improvement in health-related quality-of-life measures compared to patients who received the usual care. Patients who received the interventions experienced a reduction in emergency department visits over the two-year period, and those at high risk for repeat hospitalizations experienced a reduction in hospital admissions in the second year.

Older adults in general, especially the poor, often do not receive the recommended standard care for preventive services, chronic disease management, and geriatric syndromes, in part because most primary care practices do not have geriatric specialists on staff or the time and resources needed, says **Steven R. Counsell**, MD, chief of geriatrics and medical director for Wishard-Eskanazi Health Senior Care and director of the Indiana University Geriatrics Program at the Indiana University School of Medicine.

The GRACE program is a way to share the expertise of the hospital's geriatric staff with primary care providers to ensure that patients get the specialized care they need, he says.

"Through close collaboration between hospital clinicians and primary care providers, the limited resources of geriatricians and geriatrics interdisciplinary team can be leveraged for the greatest impact on patient outcomes," he adds.

The senior population is growing in this country, as someone turns 65 every seven seconds, adds **Kathy Frank**, RN, PhD, geriatrics program administrator at Indiana University School of Medicine. "Patients are living longer, which means that many have chronic conditions and chronic problems that include falling, dementia, incontinence, and depression. This is a unique population that has medical problems and psychosocial issues as well. The people we serve may have memory loss, hearing impairment, caregiver issues, and financial problems," she says.

The GRACE model was developed around Acute Care for Elders (ACE), an inpatient program that provides care geared to the special needs of the elderly. Seniors who are hospitalized at Wishard Memorial Hospital are often seen by the ACE consult team, an interdisciplinary team of geriatric specialists that includes a geriatrician, nurse practitioners, a nurse case manager, a pharmacist, a social worker, a physical therapist, and an occupational therapist. When they are ready for discharge, the patients are referred to the GRACE team.

Once patients are discharged, the GRACE team's nurse practitioner and social worker

EXECUTIVE SUMMARY

Wishard-Eskenazi Health in Indianapolis has developed the Geriatric Resources for Assessment and Care of Elders (GRACE) program in which hospital geriatricians collaborate with primary care providers to ensure that the elderly get the care they need.

- Patients in the program are evaluated in the home by a nurse practitioner and social worker who report back to a multidisciplinary geriatric team and develop a treatment plan.
- They share the plan with the patient's primary care provider, who can make changes and ultimately has final approval.
- They spend time with the patient and family members to discuss the plan and goals and go over the patient's medication regimen.

complete a comprehensive geriatric assessment in the home. The nurse practitioner conducts a physical examination and reconciles the patient's medication. The social worker's assessment includes psychosocial issues, functional abilities, caregivers, home safety, depression, and a cognitive screen. They work with the patient to set goals that may range from getting the heat or water turned back on to having a family meeting to discuss end-of-life options. Pain control is a frequent choice as a goal, Butler says.

The team goes back to the hospital and collaborates with a geriatrician to develop an individual care plan following the GRACE protocol. Other members of the interdisciplinary GRACE team, including a mental health social worker, a pharmacist, and community-based services liaison, review their findings and goals of the patient and add to the plan of care. When the final care plan has been developed, the nurse practitioner and social worker meet with the patient's primary care physician and share information on what they found in the home, the patient's goals, and the care plan. The physician has the opportunity to give input and to approve the plan or suggest changes.

After the primary care physician approves the plan of care, the social worker and nurse practitioner sit down with the patient and family to go over the plan and to discuss the patient's medication. "We review the medications and confirm what they are supposed to take and explain why it's important. Once they understand what a medication is for, it makes more sense to take it," Frank says. Many times, patients and caregivers are confused about what medication to take when. An extreme example is when one woman who was taking medication for depression and dementia reached into the chair cushions and showed the nurse practitioner and social worker a mason jar full of pills. She told the team that she just grabbed a few to take every day.

When the social worker and nurse practitioner start implementing the plan, they focus on the patient's initial goal in order to build trust, Butler says. They continue to provide care management and caregiver support over time and work closely with the local agency on the aging to identify services that may benefit the patients.

The team contacts the patients by telephone or in person at least monthly, depending on the patient needs. "The team typically has more contact with patients in the beginning until the services they need are in place," Butler says. After patients have an emergency department visit or hospitalization, the team meets with them again in their homes, reconfirms the plan of care, and finds out the medications they are taking, and then notifies the primary care physician about the episode of care.

The nurse practitioner-social worker teams each carry a caseload of 80 to 100 patients, ranging from those who are just released from the hospital and take a lot of time to those who are stable and need only occasional follow up.

Once patients are a part of GRACE, they're in for life unless they move out of the area or are admitted to a long-term care facility, Counsell says. The team re-evaluates them every year to determine if they still need intensive services.

"Healthcare reform is calling out for ways to improve health and lower costs. We have found a strategy to do that for a very vulnerable population. The program shows cost saving over time with the added benefit of providing services that these seniors need and can't get anywhere else," Counsell says. ■

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

■ Inpatient vs. observation: Which should it be?

■ Convincing management to approve more staff

■ What are optimal case management caseloads?

■ How your peers handle difficult discharges

CNE QUESTIONS

1. According to Adele Merenstein, JD, an attorney at Hall Render, an Indianapolis law firm, physicians can take the time patients have spent being treated as outpatients into consideration when they apply the two-midnight benchmark for an inpatient admission, but the time before the formal order is written cannot be counted as inpatient care to make the patient eligible for a skilled nursing stay.
   A. True
   B. False

2. What is the joint caseload for the nurse transitionists at Western Maryland Regional Medical Center in Cumberland, MD?
   A. 50
   B. 70
   C. 80
   D. 100

3. The emergency department observation unit at Massachusetts General Hospital is geared toward patients whose stay is expected to be how long?
   A. 24 hours or less
   B. over one midnight
   C. 12 hours or less
   D. more than 24 hours

4. At Wishard-Eskenazi Health's Geriatric Resources for Assessment and Care of Elders (GRACE) program, members of the geriatric team perform an assessment in the home and work with other team members and primary care providers to develop a plan of care. Who goes to the home?
   A. A geriatric physician.
   B. A case manager from the primary care clinic.
   C. A nurse practitioner and social worker.
   D. All of the above.

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Nurses participate in this continuing education program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■