HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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Collaborate across the continuum to ensure successful transitions

Good discharge planning is just not enough

With pressure mounting to prevent readmissions, hospitals are examining their own discharge processes and collaborating with post-acute providers and community organizations to ensure that patients have what they need to have a safe and successful transition.

"Even if hospitals could do the perfect job of communicating with patients and preparing them to leave the hospital, if there is nobody at the next provider to take up where they left off, the process will fall apart. The best transition out of the hospital is only as good as the reception into the next level of care," says **Amy Boutwell**, MD, MPP, president of Collaborative Health Strategies and co-founder of the State Action on Avoidable Rehospitalizations (STAAR) initiative of the Institute for Healthcare Improvement.

It's not enough for hospitals to develop a discharge checklist and complete a process improvement initiative aimed at improving transitions, Boutwell adds. Hospitals also should meet regularly with providers at all levels of care and have a meaningful conversation about what each of them needs, she says.

Developing a close relationship with skilled nursing facilities and home

EXECUTIVE SUMMARY

As attention focuses on preventing readmissions, hospitals must improve their internal processes and forge relationships with post-acute providers.

- Patients are most vulnerable when they move between levels of care.
- Often, readmissions occur when the receiving provider doesn't have adequate information to continue the plan of care.
- Case managers should take the time to identify patients' needs and risks for readmission and communicate clearly with the patient and caregivers about what they need to do.

care agencies is imperative in any readmission reduction program, says **Brian Pisarsky**, RN, MHA, ACM, senior managing consultant at Berkley Research Group and Centers for Medicare & Medicaid (CMS) alumni faculty for the Community-based Care Transitions Program (CCTP).

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"These providers are just as interested in reducing readmissions as hospitals are. Medicare is monitoring readmissions from home care agencies, and skilled nursing facilities don't get paid when a patient is not in their bed," he adds.

The Affordable Care Act includes incentives for readmission preventions and quality as well as financial penalties for readmissions, points out **Josh Luke**, PhD, FACHE, vice president of post-acute services at Torrance Memorial Health System in San Francisco and founder of the California Readmission Prevention Collaborative and the National Readmission Prevention Collaborative. "The penalties and incentives should encourage hospitals, physicians, and post-acute facilities to work together better," he says.

CMS and payers already are looking at increasing the number of diagnoses that result in penalties for readmission, Pisarsky points out. "I'm sure that eventually hospitals will be penalized for every readmission," he predicts.

When patients transition from the hospital to the next setting, whether it's to home or a skilled nursing facility, it's a time of heightened vulnerability, Boutwell says.

Working relationships

"At one time the idea was that when patients no longer needed to be in the hospital, they were better. Now that patients are being discharged earlier, they often have ongoing care and support needs when they leave the hospital. Hospital discharge is only a milestone in their journey of recovery, not a finishing mark," she says.

The only way to ensure that patients get the care they need when they transfer to a post-acute provider is to forge working relationships with community providers, Pisarsky says.

Luke suggests that hospitals discharge patients only to facilities that coordinate care and meet the hospital's quality standards so patients can get the same level of care they have received in the hospital. Form a network with those facilities and meet with them regularly to collaborate on care, he says. The Total Wellness Torrance Post Acute Network includes seven privately owned skilled nursing facilities, a home health agency, and a hospice. All have committed to participating in quality initiatives and data-tracking efforts. *(For details, see related article on page 28.)*

It may take a while to develop a rapport with post-acute providers since they rely on hospitals for

referrals and representatives initially may be reluctant to point out problems, Boutwell says. "But as the group continues to meet and everyone realizes that they are all there for the sake of improving care, the providers will begin to share specific and concrete information about patient care issues," she says.

When patients are readmitted to the hospital from a post-acute provider, it's often because they are sent with incomplete information or because the patient appeared different from what was in the paperwork, Boutwell says. For instance, the nursing notes might say the patient is alert and awake but the patient is confused and groggy when he gets to the skilled nursing facility and the staff send him back to the emergency department, she says.

Clear, timely communication with the receiving provider is essential, Boutwell says. "We rely on the antiquated discharge summary that may not get to the next provider for days or weeks. This is no longer acceptable. To ensure a good transition, there has to be clinician-to-clinician communication when the transition occurs. The handoff doesn't necessarily have to be physician to physician; it can be nurse to nurse or case manager to case manager," she adds.

Discharge planning should start when patients are still in the emergency department whenever possible, Pisarsky says. Hospitals are discharging sicker patients these days due to pressure from payers. This makes it imperative for case managers to start early in the stay to make sure patients have an adequate discharge plan, he says.

Case managers should conduct a comprehensive discharge planning assessment on every patient when they have been admitted or are receiving observation services, Pisarsky says. Don't make it a quick, cursory conversation. Ask questions and find out if the patient needs additional resources, he adds.

Case managers can help avoid readmissions, but if they don't have time to find out the patient's support at home or identify transportation issues or psychosocial needs, the hospital is going to be a revolving door for some patients, Pisarsky says. "Finding a reasonable ratio of patients to case managers could make the difference in hospitals staying in the black or being in the red," he says.

The responsibility for a safe and complete care transition belongs to the hospital as a whole, and not just the case manager, Boutwell says. "Transitions involve too many things across too many disciplines for just one person to be responsible," she says.

"Every patient needs a better set of basic services in the hospital to get ready to leave, whether they are the chief executive officer of a corporation, a frail elder, or a Medicaid patient. Hospitals need to raise the level of preparation and communication for patients across the board for everyone," she says.

In addition, hospitals must identify people with specific needs or risks in real time while they are still in the hospital, she adds. "There are a lot of readmission risk assessment tools available, but none are perfect. Hospitals need to adapt one of the tools for their own use or come up with a way to identify patients' needs," she says.

Hospital staff must communicate with patients and family members more clearly and consistently while they are in the hospital. "So often, nurses, doctors, and case managers whiz in and out and the patient and family is left with an incomplete picture of why patients are in the hospital, where they are going next, and what the patient and family needs to do after discharge," she says.

Case managers or other hospital staff need to make a follow-up appointment with their primary care provider or specialist while the patient is still in the hospital, make sure the patient can get to the appointment, and line up transportation if it's needed, she says. "It's not enough just to tell patients to follow up. Most readmissions are within two weeks," she says.

Collaborate with the patient's insurance plan's case managers to prevent high-risk patients from coming back, Pisarsky suggests. "Insurance companies don't want readmissions, either," he says.

It's essential for hospitals to develop a successful readmissions program, but it will take a lot of work, Pisarsky says. Start by reviewing your readmissions and drill down to find out why they occurred, he suggests. When patients are readmitted, talk to the patient and find out what happened — or didn't happen — to make the discharge plan fail, he says. When readmissions occur from home care or a post-acute facility, meet with the patient and the provider and find out what could have been done differently to keep the patient from coming back, Pisarsky suggests.

There's no one-size-fits-all solution to improving discharge planning, Boutwell says.

How hospitals assure safe transitions will vary from organization to organization. "The important thing is to get these tasks done," she says. ■

Program bridges acute, post-acute care

Network of providers meet with hospital reps

As part of its Total Wellness Torrance readmission reduction program, Torrance (CA) Memorial Health System has created its own network of post-acute facilities and works closely with them to coordinate care during transitions and for 30 days after discharge from the acute care hospital.

The program also includes a readmission prevention protocol in the emergency department to reevaluate readmitted patients and identify alternative levels of care to a hospital readmission, a Care Transitions program with staff who meet weekly with post-acute providers to collaborate on care for patients, and a Care Coordination Center, a post-discharge clinic where clinicians perform medication reconciliation and review the discharge instructions with the patient and family members.

"This program bridges the gap between acute care at hospitals and post-acute care at nursing facilities, working to rehabilitate patients and return as many as possible to their own homes. Nursing homes have joined together with the local hospital to improve quality of care in the community," says **Josh Luke**, PhD, FACHE, vice president of post-acute services at Torrance Memorial Health System and founder of the National Readmission Prevention Collaborative.

The Total Wellness Torrance Post Acute Network includes seven privately owned freestanding skilled nursing facilities, as well as a home health agency and a hospice, both of which are affiliated with the health system. All of the post-acute network members have committed to participating in quality initiatives and data-tracking efforts. Their staffs collaborate with Torrance Memorial's case management staff to ensure safe transitions and coordinate care and discharges for patients during the post-acute stay.

"We gave the providers in our area a set of quality guidelines and chose to work with the ones who have committed to our quality initiatives and are interested in coordinating care for our patients. We work with the skilled nursing facilities like an integrated network even though we are not. The network includes only facilities within five miles, which allows for improved coordination and collaboration with the skilled nursing facilities," Luke says.

Representatives from the hospital, including attending physicians, meet with skilled nursing facility representatives every other month and discuss current trends, legislative updates, how transitions are going, readmission rates, and how to improve communication and care coordination. The result has been a smoother handoff for patients and a shorter length stay on the acute care side as physicians feel more comfortable that patients are going to be well cared for at the next level of care, Luke says.

Care for the patients in the hospital may be coordinated by a trio of case managers who work together closely. The acute care case manager coordinates care during the hospital stay and works with the treatment team to develop a discharge plan. A patient navigator educates patients with post-acute needs on the health system's post-acute Care Transition program, and works with the ambulatory case manager who follows patients while they are receiving care from post-acute providers.

When the physicians write a discharge order, they have the option to check a box admitting the patient into the Care Transition program. This triggers a consultation by a patient navigator, a case manager with a close working relationship with the hospital's post-acute network, who meets with patients, describes the program and the participating providers, and gets the patient's agreement to participate. "While patients are still presented a complete list of post-acute providers from which to choose, the Care Transitions program includes only preferred providers," Luke says.

After the patient consents to the program, the navigator hands the patient back off to the

EXECUTIVE SUMMARY

Torrance (CA) Memorial Health System instituted Total Wellness Torrance, a multi-pronged approach to reducing preventable readmissions.

- The hospital created a post-acute network of providers that agree to participate in quality improvement initiatives and who meet regularly with hospital representatives.
- Care Transitions staff meet weekly with post-acute providers to collaborate on patient care and the discharge plan.
- The hospital operates a Care Coordination Center, a post-discharge clinic where clinicians go over the treatment plan and conduct medication reconciliation.

acute care case manager to facilitate the transfer. Each week, the ambulatory case manager and the navigator meet with the staff at each skilled nursing facility, talk about each patient, and discuss the discharge plan and whether the patient will require home health or other services. As discharge approaches, the team makes sure the patient has a follow-up appointment at Torrance Memorial's Care Coordination Center and that the patient will have transportation to the appointment.

When Medicare patients who were discharged from the hospital come into the emergency department within a 30-day period, the hospital's electronic medical record system alerts the hospital's readmission prevention manager by email in real time. The readmission prevention manager meets with patients in the emergency department, finds out why they are back, and works with them and the emergency department staff to identify an alternative level of care that would be a more appropriate placement that an acute hospital admission. The readmission prevention manager also educates the patient on alternatives to returning to the emergency department and may schedule an appointment with the health system's Care Coordination Center. ■

Partnership aims to cut unnecessary ED use

Model teams paramedic, advanced practice nurse

By working together, Scottsdale (AZ) Health System and the City of Scottsdale Fire Department have developed model in which a paramedic from the fire department and an advanced practice nurse from the hospital would treat patients who call 911 but don't need care in the emergency department, provide follow-up assessment for patients who are at risk for hospital readmissions, and transport appropriate behavioral health patients directly to a behavioral health provider, avoiding an emergency department visit.

The initiative grew out of the hospital system's initiative to improve care by meeting regularly with community organizations that provide services to the elderly to collaborate on ways to improve transitions. For details, see the October 2013 issue *Hospital Case Management* ("Team focuses on needs of the elderly," page 138).

"We are making a lot of effort with our community partners to provide appropriate services at the right level of care," says **Karen Vanaskie**, MSN, RN, director of case management, Scottsdale Health System.

Representatives from the health system's case management department and the fire department have been meeting for several months to develop the model and are collecting the data they need to make a formal request for funding. The representatives from the fire department are tallying the types of calls that would be appropriate for the initiative and the number of repeat visits the paramedics make in cases that don't require emergency treatment. Hospital staff are compiling data on discharge and return rates and patients with low acuity and behavioral health issues who come to the emergency department.

"We are working together to meet the needs of our community. The hospital needs a way to see that patients with non-emergent needs are not coming to the emergency department, and we need a way to make sure that the 911 system is not utilized for things other than emergent care," says Scottsdale Fire Chief **Tom Shannon**.

The paramedic-nurse team would work out of a specially equipped vehicle similar to an ambulance and receive referrals from the 911 alarm center based on telephone triage by a medical professional and priority dispatch as well as referrals from the hospital case managers.

When patients call into 911 with low-level complaints that don't require emergency department

EXECUTIVE SUMMARY

Scottsdale (AZ) Health System and the City of Scottsdale Fire Department are teaming up to treat patients at the right level of care and avoid unnecessary trips to the emergency department and hospitalizations.

- In the model, a paramedic from the fire department and an advanced practice nurse from the hospital will take calls to 911 that the medical triage staff determines are low-level complaints that do not require a trip to the emergency department.
- The nurse-paramedic team will also make follow-up visits to discharged patients who may be at risk for readmissions.
- They will be equipped with videoconferencing equipment they can use to consult with behavioral health providers and, when appropriate, transfer patients with mental health problems directly to a provider, eliminating an emergency department visit.

services, the team would be able to treat them in their home and refer them to a physician network or primary care provider for follow up.

For instance, patients who have a small cut that needs just a few stitches or people who have fallen and need help getting up would be triaged to the team. "We want to provide an alternative to an emergency department visit for patients with low-level needs," Shannon says.

Many of the patients who likely would be treated by the paramedic-nurse team are elderly and call 911 multiple times each month for minor problems, says Assistant Fire Chief **Eric Valliere**, who heads the fire department's professional services. "A significant number of these calls involve falls. One of the responsibilities of the team would be fall and injury prevention education," he adds.

The team would also receive referrals from hospital case managers who request follow-up visits in the home for patients who are being discharged and have a high risk for readmission. In those cases, the team would check to see that the patients have filled their prescriptions and are taking their medication, check vital signs, and determine if the patient needs additional support such as help with meals or transportation. "My goal is that the case manager in the hospital has someone to alert about a person who might be at risk for readmission and who could check on them for the first few days after discharge. The team would be our eyes and ears in the home and could alert us that we need to set up community resources for the patient," Vanaskie says.

Paramedics already alert the hospital staff when they get a call to a home where the patient needs community resources, such as help with utilities or other support, Vanaskie says. "We want to take a proactive approach so the case managers can refer people they are concerned about and the paramedic-nurse team can identify the need and alert the case managers before the patient calls 911," she adds.

The team also would be educated to deal with people with behavioral health issues and use a secure videoconferencing line to consult with behavioral health professionals on the scene.

"If we can get the patients assessed on the scene, they won't have to be seen in the emergency department and can go right to behavioral health. Our goal is to get patients care in the right destination," Valliere says.

The program would go a long way to optimizing the resources of both the fire department and the hospital, Shannon says.

"A good portion of our community uses 911 and the emergency department as their primary care physician. We are looking at ways to alleviate this problem, prevent some unnecessary visits, and provide the care patients need in the appropriate setting," Shannon says. ■

Hospitals, SNFs team to prevent readmissions

Better communication improves transitions

By improving communication and developing a close working relationship with staff at local nursing facilities, Duke Raleigh Hospital has improved transitions and reduced readmissions from the nursing facilities.

In addition to participating in a community-wide collaborative of hospitals, skilled nursing facilities, and assisted living facilities, the case management staff at the community hospital have visited nursing facilities in person and met with senior leadership to discuss ways they could collaborate for better transitions.

"We have gotten to know the staff at the nursing facilities, and that makes communication easier when patients transition. We have discussed goals and worked on ways to improve the process," says **Pat Kramer**, Ed.S, CCM, CSW, NCC, director of case management, who visited the nursing facilities with **Karen Preston**, RN, BSN, CCM, inpatient team leader and care transition case manager.

For instance, discussions with the staffs at the nursing facilities led to a nurse-to-nurse report when patients are being discharged from the hospital to a nursing facility. "The purpose of the

EXECUTIVE SUMMARY

Duke Raleigh Hospital participates in a community-wide collaborative of hospitals and post-acute providers but also has developed close relationships with individual skilled nursing facilities.

- Discussions resulted in nurse-to-nurse reports when patients transition.
- The hospital staff provided education on peripherally inserted central catheter (PICC) line care and wound care to nursing home staff.
- SNFs alert the hospital team when patients are being transported to the emergency department.

CASE MANAGEMENT INSIDER
Case manager to case manager

Centers for Medicare and Medicaid Services — Conditions of Participation for Utilization Review

By Toni Cesta, PhD, RN, FAAN

Introduction — The Utilization Review Process

As we have discussed in prior months, hospitals that are participating in the Medicare and Medicaid programs — meaning that they receive reimbursement from Medicare and/or Medicaid — are required to participate in Medicare's "Conditions of Participation" (CoP). The CoP includes the actions that hospitals are required to perform in order to continue to participate in the Medicare and Medicaid programs. They are required and not optional.

As discussed, case managers are bound to two of the components of the CoP. These are the discharge planning sections and the utilization review sections. This month, we will review the CoP for utilization review.

The First Role of Case Managers

Utilization review was the first role assumed by hospital case managers. It was a stand-alone role and was performed as a requirement under the Medicare program. As the case management models evolved, utilization review was subsumed as one of many roles performed by hospital case managers. Whether your case management model applies utilization review as a stand-alone role, or whether it is part of an integrated approach, your hospital is bound by the components of the CoP for utilization review. Therefore, it is critical that you are aware of what these requirements are and that they are also included in the hospital's utilization review plan.

Section 482.30 Issued and Effective on 10/17/08

The section on utilization review starts with the basic requirement of the section. It states the following:

"The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs."

The hospital's utilization review plan should include the following:

- a delineation of the responsibilities and authority for those involved in the performance of UR activities;
- procedures for the review of the medical necessity of admissions;
- the appropriateness of the setting;
- the medical necessity of extended stays; and
- the medical necessity of professional services.

The Utilization Review Committee

The utilization review committee must include two or more practitioners who carry out the utilization review functions. At least two members of the committee must be doctors of medicine or osteopathy. The other members can be any type of practitioner.

The UR committee must be one of the following:

- a staff committee of the institution that has delegated to the UR committee the authority and responsibility to carry out the UR functions
- a group outside the institution
  - established by the local medical society and some or all of the hospitals in the locality; or
  - established in a manner as approved by CMS (The Centers for Medicare & Medicaid Services).

If your hospital is too small to practically

have a functioning UR committee, then a committee must be established as per above.

The committee's reviews cannot be conducted by any individuals who have any of the following:

• a direct financial interest in the hospital (an example would be an ownership interest) or

• were professionally involved in the care of the patient whose case is being reviewed.

Section 482.30(c) Standard: Scope and Frequency of Review

This section discusses the manner in which clinical reviews must be conducted. This information must be included in the utilization review plan as well.

• The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of:

- admissions to the institution
- direction of stays, and
- professional services furnished including drugs and biologicals.

• Review of admissions may be performed before, at, or after admission to the hospital.

• Reviews may be conducted on a sample basis.

• Hospitals that are paid for inpatient hospital services under the prospective payment system must conduct review of duration of stays and review of professional services for:

- For duration of stays, these hospitals are only required to review cases that they reasonably assume to be outlier cases based on extended length of stay.
- For professional services, these hospitals need only review cases that they reasonably assume to be outlier cases based on extraordinarily high costs.

Implementing Review Frequency

While the CoP states that reviews may be conducted on a sample basis, except for extended stays, most contemporary case management departments review all admissions to the hospital. Due to the changes in Medicare payments including the two-midnight rule, reductions in payment for readmissions and so forth, it has become necessary to look at all admissions at the start of the stay and daily thereafter. In the case of extended stays, less frequent reviews may be appropriate.

The UR plan should include the hospital's expectations concerning reviews for medical necessity with respect to admission, duration of stay, and the professional services furnished. If your hospital is not paid under the prospective payment system, then these rules are not applicable.

Section 482.30(d) Standard: Determination Regarding Admissions or Continued Stays

The CoP tells us that the determination that an admission or continued stay is not medically necessary

• may be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient concur with the determination or fail to present their views when afforded the opportunity; and

• must be made by at least two members of the UR committee in all other cases.

• Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the patient, and afford the practitioner or practitioners the opportunity to present their views.

• If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given. This notification must be given no later than two days after the determination, and must be given to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient.

Applying the Rules for Admission and Continued Stay Reviews

When someone other than a physician makes an initial finding that an admission or continued stay does not meet criteria, the CoP gives specific instructions as to how the process should be conducted. Generally, it is the case manager who is making these initial determinations, and the case manager is usually a registered nurse. However, the CoP requires that, if the criteria are not met, the case be referred to the utilization review committee or sub-group of the UR committee. This sub-group must contain at least one physician. In most hospitals, this would be the physician advisor.

The committee or physician advisor is then required to review the case. If the physician advisor agrees that the case does not meet the

hospital's criteria for admission or continued stay, then the attending physician must be notified. The attending physician must be given an opportunity to present his or her views and any additional information relating to the patient's needs for admission or extended stay.

Clinical Criteria and Utilization Review

It is important to apply the role of the clinical documentation improvement specialist (CDI) into this process. For example, if you, as the case manager reviewing the record, determine that the documentation does not support medical necessity for admission or continued stay, you may also note that the patient's clinical condition and other factors seem to support the admission. Before contacting the physician advisor, you should consider contacting the CDI specialist to review the record and query the physician if additional documentation is warranted and would support the admission. In some cases, it is strictly the addition of more comprehensive documentation that is needed to support the admission or continued stay. This step should always be considered so that the physician advisor is only contacted when no other solution is available at that point in time.

The Physician Advisor

Once the documentation is in order, and the case still does not meet clinical criteria for admission or continued stay, then the physician advisor must be contacted. The physician advisor, after reviewing the case, may determine that the stay does not meet medical necessity. If the attending of record does not respond or does not contest the findings of the physician advisor, then the findings are final.

If the attending physician contests the decision of the utilization review committee or the physician advisor or if the physician of record presents additional information related to the patient's stay, then at least one additional physician on the UR committee must review the case. If the two physician members agree that the patient's stay is not medically necessary or appropriate after considering all the evidence, then their determination becomes final. Written notification of this determination must be sent to the attending physician, the patient (or next of kin), the hospital administrator, and the state agency (if a Medicaid patient) no longer than two days after the final decision, and no more than three working days after the end of the assigned extended stay period.

The CoP also points out the schedule that they expect hospitals to follow. They state that there are five working days in a week and that normally these days are Monday through Friday. They go on to say that if the hospital prefers to use a different five days, for example Tuesday through Saturday, they are welcomed to establish this in their UR plan and operations. When a holiday falls on one of those days, then the holiday is not counted as one of the five working days.

If the case manager makes a referral to the physician advisor questioning the medical necessity of an admission or continued stay, and the physician advisor determines that the admission or continued stay is justified, the attending physician is then notified. An appropriate date for subsequent review, if appropriate, is then determined and noted in the patient's medical record.

This notification must also be sent to the attending physician in writing, the patient (or next of kin), the hospital administrator and the single state agency (in the case of Medicaid) no later than two working days after the final determination is made, and in no event longer than three working days after the end of the assigned continued stay period.

For example, if the physician advisor reviews that case and determines that continued stay is approved for two days, then another review and determination must be made by the end of those two days.

Who May Make Final Determinations

The Conditions of Participation for utilization review are very clear as to who in the hospital can make final determinations regarding a patient's level of care. They state "in no case may a non-physician make a final determination that a patient's stay is not medically necessary or appropriate." This point clearly requires that the hospital have an active physician advisor in place and that all cases deemed not meeting medical necessity by the case manager are referred to the physician advisor. Many hospitals do not have this process in place and therefore would be out of compliance if audited on this Condition of Participation.

Ensuring Compliance

It is prudent to conduct chart reviews on a random-sample basis to ensure that you are in

compliance with the CoP. Elements to review would include the following:

- Review a sample of records found to be medically unnecessary (not meeting clinical criteria for admission or continued stay) and determine if these decision were made by:
  - One member of the UR committee, if the practitioner responsible for the patient's care concurs with the determination or fails to present his or her views.
  - At least two members of the UR committee in all cases not qualified in the above bullet.
- Review a sample of records found to be medically unnecessary (not meeting clinical criteria for admission or continued stay) and verify that the physician was informed of the committee's expected decision and was given an opportunity to comment.
- Review a sample of records found to be medically unnecessary (not meeting clinical criteria for admission or continued stay) and verify that all involved parties were notified of the decision that care was not medically necessary no later than two days following the decision.

Section 482.30(e) Standard: Extended Stay Review

The CoP refers to long-stay patients as extended stay. They define extended stay as patients whose length of stay has reasonably exceeded the threshold criteria for the diagnosis as determined by the hospital. This threshold is determined by the prospective payment system's expected length of stay for the diagnosis-related group and then the hospital can define what it considers to be extended beyond that. The hospital is not required to review an extended stay that does not exceed the outlier threshold for the diagnosis.

The utilization review committee must review the record no later than seven days after the day required in the utilization review plan. Therefore the UR plan must include the hospital's own definition of what an outlier patient is.

This section of the CoP is dependent on a definition in the UR plan that specifies what the hospital considers an extended stay. Most hospitals use this definition to review cases for medical necessity but also for delays related to discharge planning issues.

Defining Long Length of Stay (Extended Stay)

Most hospitals define long length of stay as cases that exceed a pre-determined length of stay. For the majority of hospitals, this is stays with a length of stay greater than seven days. If however, you find that this length of stay leaves too many cases to review, you can change your definition to greater than ten days. The frequency of review of these cases should also be defined in the UR plan. Best practice calls for weekly review of these cases to ensure that progress is being made and interventions are happening as needed.

While not common, some hospitals may use different thresholds for different diagnoses. If your hospital chooses to do this, then there must be a written list of the lengths of stay for each diagnosis. Clearly this can be a cumbersome and difficult process to operationalize and is why most hospitals choose to have one extended stay threshold that applies to all patients.

The review of these cases should be included in the minutes of the utilization review committee.

Audits

If the hospital's utilization review plan and process are audited, the auditor will review the minutes in addition to discussing the process with the case management staff. Each case manager should have a copy of the UR plan and should be familiar with it. If the hospital has an intranet where documents are kept, the UR plan can be kept there as well.

Summary

As case managers, the UR plan and the CoP are important tools that guide our daily work. It is important to be familiar with all CoPs that apply to case management and to review these on a regular basis! ■

Next Month from Toni Cesta:
The 2-Midnight Rule – A Game Changer for Case Management

calls is to let the nurse know what has been going on with patients during the hospital stay and when they need their next dose of medication. It also gives patients a sense of security when we tell them that the nurse taking care of them is calling the nursing home where they are going so that facility will have the latest information," Preston says.

When they visited the nursing facilities, Kramer and Preston discussed the importance of making sure the patients' primary care physicians receive a discharge summary when patients leave the nursing facility and that patients have a follow-up appointment.

"When patients leave one facility for another, it's a transition, not a discharge. Responsibility for the patient doesn't stop when they are discharged from the hospital or nursing facility. We want everybody to think about the next 30 days rather than just getting them out the door," Kramer says.

When the staff at one of the nursing facilities asked for education for their nurses on peripherally inserted central catheter (PICC) line care, Kramer and Preston arranged for a PICC line expert from the hospital to teach PICC line care for both shifts of nurses. The hospital also partnered with a nursing facility on wound care education.

Preston calls the nursing facilities after patients have been transferred to make sure the facility has all the paperwork and other information it needs to continue the plan of care. For instance, when Preston follows up on patients who were treated for a urinary tract infection, she makes sure there is follow-up lab work. Otherwise, if the infection persists, the patient is likely to have a change in mental status and end up back in the hospital.

"When patients move from one level of care to the other, things can fall through the cracks. The physician at the hospital may recommend a follow-up test in the discharge summary, but the nursing facility doctor still has to order it. We focus on making sure that everybody owns the patient together," she says.

The follow-up phone calls have helped prevent readmissions in several instances when patients left the nursing home against medical advice. "Sometimes patients get to the nursing facility they have chosen and don't like it. In the past, we did not know the patients had left the facility until they ended up back here. Now we can contact the patient and arrange an admission to another facility or arrange for home health and any equipment the patient needs," Kramer says.

Meeting with and getting to know the staff at the nursing facilities has improved communication and helped make the staff feel comfortable calling the hospital if there is a problem with a patient who has transferred, Preston says. For instance, when a patient lost consciousness for a short period of time, the nursing home called Preston, who called the emergency department to communicate the patient's condition and that he was a resident of a facility that was happy to take him back after treatment.

In another instance, a nursing facility contacted Preston about a patient who was having complications and had been to the emergency department twice. "We talked to his doctor and had the hospitalist admit him directly. This kept the patient from sitting in the emergency department for hours and saved an emergency department visit," she says.

The case management directors and medical directors for case management at three hospitals in Raleigh, including Duke Raleigh, began meeting with representatives from local nursing homes in 2011 on ways to improve communication and transitions. "At first, we met with the nursing homes each of the hospitals referred to the most, but then we opened it to all the skilled nursing and assisted living facilities in the area," Kramer says.

The group started out meeting monthly and educated each other on regulations and procedures they must follow and the pressures that each type of organization faces. Now the group has quarterly meetings and invited speakers on a variety of topics such as health literacy and the Interventions to Reduce Acute Care Transfers (INTERACT) tool.

The nursing facilities have started using the INTERACT tool when they transfer patients to the hospital. One chain of facilities put the tool in a red folder so the emergency department staff can find it easily. "This tool is so valuable for patient safety and patient satisfaction. It eliminates duplication and gives us a head start on our treatment plan," Kramer says.

Members of the community coalition serve on subcommittees that focus on various issues. For instance, the education committee has developed a one-page flyer for patients and family members with information aimed at making transitions between levels of care easier. The flyers inform people of what to expect, such as that most nursing facilities don't have private rooms, patients

won't be seen by a doctor every day, and beds don't usually have side rails.

"The flyers are unbranded and can be used by any facility. They are written in plain language with health literacy in mind and reviewed by focus groups of patients and family members. We give them this information verbally, but it helps to have it in writing, too," Preston says. ■

ED staff, paramedics work to reduce readmits

Team develops care plans for at-risk patients

The emergency department staff at Duke Raleigh Hospital has forged a relationship with the Wake County's advanced practice paramedics to improve patient care and reduce readmissions.

"The advanced practice paramedics are our eyes and ears in the patient homes. The emergency department case managers don't always get the complete story about what is going on with patients. The paramedics see firsthand what their home situation is like and what their support system really is," says **Denise Gregory**, RN, BSN, ACM, team leader, emergency department case managers.

Gregory meets once a month with the advanced practice paramedics and representatives from the area's Medicaid managed care network, which also coordinates care for the aged, blind and disabled, and Medicaid managed care organization for mental health care.

"We discuss cases that we have in common and develop strategies and interventions to help patients get to the right place and the right level of care. When we bring up patients at the meetings, most of the time, everybody at the table is familiar with them. About 80% of the patients are receiving care from everybody," Gregory says.

The group currently has about 35 care plans in place for patients who are at high risk, most of whom are high utilizers of health care with complex conditions and multiple comorbidities.

The care plan includes demographics, past medical history, names of the primary care provider and any specialists treating the patient, what the home situation is like, if a case manager is assigned, and other pertinent information. Patients are involved in setting goals for the plan. "Patients don't want to be in the hospital, but they need help connecting with appropriate services. Sometimes the goal is to link the patient to a specialist with an office in a convenient location or to help them stay pain free. Most of the time, we can link them with specialists or programs that can help them," she says.

Some of the patients have transportation issues that keep them from seeing primary care providers. Others have social needs, but often won't mention them to the hospital staff.

"The advanced practice paramedics get the back story of what is going on at home that the patients are embarrassed to mention. They help us tear down the walls that are contributing to the patients' conditions," she says.

There have been several instances when the paramedics mentioned that the utilities had been turned off in a patient's home. "We were able to get them turned back on, but even though we had conducted an assessment that included social needs, we had no idea the utilities had been turned off until the paramedics told us," she says.

The care plans are uploaded into the Medicaid provider portal so that all hospitals and physician offices have access. "We cover all the bases. Everybody brings something to the table," she says.

When the paramedics get a call about one of the patients in the initiative, they already have their care plan and their destination. "The paramedics call me when they are en route to the hospital and let me know what is happening so

EXECUTIVE SUMMARY

Duke Raleigh Hospital's emergency department staff and the county's team of advanced practice paramedics work together to prevent readmissions among patients who are high utilizers of the healthcare system.

- Working with Medicaid managed care organizations, the team has developed care plans to help get at-risk patients the right care at the right place.
- The team involves the patients in setting goals and creating the care plans.
- The paramedics assess the home situation and psychosocial needs and alert the hospital's case management staff.

the emergency department doctors can be prepared," she says.

Since the advanced practice paramedics are trained to do medical screening in the field, they often don't have to take patients with mental health issues to the emergency department. They can transport them directly to a mental health facility.

They also can assist the emergency department case managers in making sure the patients stay safe in the community. "When there's an elderly person who lives alone or someone with a lot of comorbidities, we can ask the paramedics to check their medication, take their blood pressure, or look for swelling," Gregory says.

The goal of the program is to prevent overutilization. "One of the goals of the program is to prevent overutilization, but the more important goal is to get patients to the right place, and the emergency department is not always the right place," Gregory says. ■

Supervisors are key to creating safety climate

Safety leaders: Perception becomes reality

"Safety culture" has been an important buzzword in occupational health for many years. But recent research shows that the broad goal has one key component: The attitude of supervisors.[1]

"The positive work environment is strongly related to positive employee outcomes — and patient outcomes," says **Deirdre McCaughey**, PhD, MBA, assistant professor of health policy and administration at The Pennsylvania State University in University Park.

McCaughey and colleagues studied the work environment among a group of hospital employees who are often overlooked — food service and environmental services workers. They probed workplace perceptions among 1,272 support workers at 11 acute care hospitals. The study used well-established patient safety questionnaires as a basis, altering the wording to reflect employee safety.

For example, workers assessed whether it was true that ''the actions of hospital management show that worker safety is a top priority'' or whether worker safety is ever sacrificed to get more work done. Workers also gave their units an overall safety grade — from failing to excellent.

"We found that there's a positive relationship between supervisor safety leadership and [employee] safety perceptions," McCaughey says. "When employees see that their unit supervisor engages in and takes safety seriously, the employees are going to have higher safety perceptions and they're going to rate their unit as a safer place to work in."

The same association exists between the safety leadership of senior management and worker perceptions, she says.

In this case, perception is also reality. Employees with lower perceptions of safety were more likely to report having been injured. "The odds of being injured are substantially reduced when employees have these [positive] safety perceptions," McCaughey says. "When they have poor perceptions, they're twice as likely to report having been injured."

Co-worker support also plays an important role, she found. Workers who reported higher levels of coworker support also had a higher perception of safety and fewer reports of injuries.

The research demonstrates the importance of setting priorities and expectations for safety, McCaughey says.

It goes beyond establishing policies or providing safety training, she says. Strong leaders build cohesive teams and emphasize collaboration and they demonstrate that employee safety is a priority, she says.

The findings show that safety leadership and coworker support are important components of safety climate. That holds true for both patient safety and worker safety, McCaughey says.

"The cognitive mechanisms that create a safe environment for a worker are the same mechanisms that create a safe environment for patients," she says. "Greater emphasis on safety promotes employee safety compliance, resulting in safer outcomes for everyone."

REFERENCE

1. McCaughey D, Halbesleben JRB, Savage GT, et al. Safety leadership: Extending workplace safety climate best practices across health care workforces. *Advances in Health Care Management* 2013; 14:189-217. ■

CDC: Influenza shots prevent hospitalizations

Hospitals post high rates, LTC lags

Here's another reason to emphasize influenza vaccination in long-term care: Last year, vaccination prevented an estimated 44,000 flu-related hospitalizations among older people, according to the Centers for Disease Control and Prevention.

CDC regularly stresses that "the best way you can protect yourself against the flu is to get a flu vaccine," as director **Thomas Frieden**, MD, MPH, said in a press conference. But now the public health agency has some numbers to illustrate that.

The 2012-2013 season was a relatively severe flu season, with about 381,000 flu-related hospitalizations, Frieden said. Based on that, and data on flu vaccine coverage and effectiveness, researchers estimated that a total of 6.6 million cases and 79,000 hospitalizations were averted.

Flu-related hospitalizations occur most frequently among the elderly and children four and younger. "Much of the illness and hospitalizations that we prevented was in the most vulnerable people, the youngest and the oldest," says **Ann Schuchat**, MD, director of CDC's National Center for Immunization and Respiratory Diseases.

CDC has no data on the impact of increasing vaccination rates among hospital employees, Schuchat said. "The best data about the impact of health care worker vaccination is older data that suggests a real benefit for patients in long-term care facilities when high proportions of the health care workers there are vaccinated," she said. "Sadly, that is the population of health care workers where we've really been lagging behind."

Influenza activity typically peaks between January and March, so by the end of 2013, there were only early reports of outbreaks.

"Seasonal influenza activity is now beginning to increase in parts of the U.S. and we know that it will increase in the coming weeks and months, but we cannot predict where and when and how severe this year's flu season will be," Frieden said.

Influenza vaccination seemed to be on track to mirror the coverage from the prior season among health care workers, according to a CDC survey.

"By mid-November, we were pretty much where we were the year before," said Schuchat, adding that "63% of health care providers had gotten flu vaccine by that point this year, just about the same as last year."

Coverage was higher in hospitals, with a vaccination rate of 79%. The rate was 60.5% in ambulatory care and just 52.6% in long-term care, CDC reported.

About half of hospital workers in the Internet-based survey reported that their employer required the flu vaccine. Not surprisingly, those with an employer requirement had the highest vaccination rate — of 90%. Only 10% of health care workers in long-term care reported that their employers have a flu vaccine requirement.

Pharmacists were the most likely to get the vaccine, with a rate of 90%. Physicians and nurses also had high rates, of 84% and 79%. Aides or assistants were the least likely to be vaccinated, with a rate of 49%.

The survey also revealed some attitudes about influenza vaccination:

- About one-quarter of health care workers who did not plan to be vaccinated said the reason was, "I just don't want the vaccine." Another 25% feared getting influenza from the vaccine or having side effects.
- Health care workers said their main reason for getting the flu vaccine was "to protect myself from flu" (42%). Only 5.6% said protecting patients was the main reason they received the vaccine.
- Workers who were 65 or older were slightly more likely to receive the vaccine than younger workers.

Schuchat emphasized that the vaccination numbers were just a "halftime" report, and that CDC encourages vaccination throughout the flu season. "It's really where we are at the end of the season that matters," she said. ■

Joint statement on vaccine mandates

Three leading infection prevention organizations issued a joint statement urging mandates for all federally recommended health care worker vaccinations. Those groups are: The Infectious Diseases Society of America (IDSA), the Society for Healthcare Epidemiology of America (SHEA), and the Pediatric Infectious Diseases Society (PIDS).

The organizations urge hospitals that have not reached at least 90% vaccination coverage to make the recommended vaccines "a condition of employment, unpaid [volunteer] service, or receipt

of professional privileges."

The statement continues, "For HCP who cannot be vaccinated due to medical contraindications or because of vaccine supply shortages, health care employers should consider, on a case-by-case basis, the need for administrative and/or infection control measures to minimize risk of disease transmission (e.g., wearing masks during influenza season or reassignment away from direct patient care).

"The societies also support requiring comprehensive educational efforts to inform HCP about the benefits of immunization and risks of not maintaining immunization."

The complete statement is available at www.sheaonline.org. ■

Hospitals concerned about final pay rules

The Centers for Medicare & Medicaid Services (CMS) has announced a final rule for hospital outpatient services, or the Outpatient Prospective Payment System (OPPS). CMS estimates that the rule will increase payments for hospital outpatient departments by 1.7%, according to the National Association of Healthcare Access Management (NAHAM). The new rule was effective Jan. 1, 2014; however, CMS will delay implementation and final configuration of the new 29 comprehensive ambulatory payment classifications (APCs) until 2015, NAHAM says.

The rule will create 29 comprehensive APCs to handle payment for device-dependent services and will require direct supervision for a range of outpatient services in critical access hospitals (CAHs).

This rule combines five payment codes into a single payment code that covers all outpatient clinic visits. The outpatient clinic visits code will include drugs, biologicals, and radiopharmaceuticals used in a diagnostic test or surgical procedure, lab services, and device removal procedures. The American Hospital Association believes that the payments will be well below the cost of treatment for complex patients, according to NAHAM.

The Access to Medical Imaging Coalition is concerned that the rule will dramatically reduce the outpatient payments to hospitals for CT scans and MRI services, NAHAM says. The group is concerned because the rule will establish similar reimbursement rates for a CT scan and X-ray image of the same body part, even though a CT scan requires more expensive equipment and is more expensive to administer. ■

CNE INSTRUCTIONS

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

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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

■ Are you providing culturally competent care?

■ Toni Cesta on the "two-midnight" rule.

■ Discharge planning for hard-to-place patients.

■ How your peers are preparing for Medicare audits.

CNE QUESTIONS

1. According to Amy Boutwell, MD, MPP, president of Collaborative Health Strategies, when patients are readmitted to the hospital from a post-acute provider, it's often because they are sent with incomplete information or because the patient appeared different from what was in the paperwork.
   A. True
   B. False

2. What are the components of Torrance (CA) Memorial Health System's Total Wellness Torrance readmission reduction program?
   A. A readmission preventions protocol in the emergency department and regular meetings with a network of post-acute providers.
   B. A Care Transitions program with a staff who meet weekly with post-acute providers to collaborate on care and a Care Coordination Center, a post-discharge clinic.
   C. Nurse-to-nurse calls when patients are transitioned to another level of care and home health services for patients being transferred to home.
   D. Both A and B.

3. Scottsdale Memorial Health System and Scottsdale Fire Department have developed a model for a paramedic and an advanced practice team to visit patients in the community. What will the team do?
   A. Treat patients who call 911 but don't need care in the emergency department.
   B. Provide follow-up assessments for patients who are at risk for hospital readmissions.
   C. Transport appropriate behavioral health patients directly to a behavioral health provider, avoiding an emergency department visit.
   D. All of the above.

4. Representatives from Duke Raleigh Hospital's emergency department team, Wake County advanced practice paramedics, the area's Medicaid managed care network, which also coordinates care for the aged, blind and disabled, and the Medicaid managed care organization for mental health care meet monthly and develop care plans for vulnerable patients. What percentage of patients they discuss are familiar to all of the team members?
   A. 50%
   B. 70%
   C. 80%
   D. 90%

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