HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

October 2014: Vol. 22, No. 10
Pages 133-144

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Financial Disclosure:
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CMS keeps raising the stakes on quality improvement

IPPS continues the focus on performance

If there ever was any doubt that the Centers for Medicare & Medicaid Services (CMS) is serious about improving quality, the 2015 Inpatient Prospective Payment System final rule should dispel that notion. A significant portion of the lengthy final rule is devoted to quality improvement initiatives.

In fiscal 2015, beginning October 1, hospitals have the potential to lose as much as 5.5% of their Medicare base payment if they perform poorly on all the quality initiatives. This includes 1.5% in the Hospital Value-based Purchasing Program, 3% in the Hospital Readmission Reduction Program, and 1% in the Hospital-Acquired Condition Reduction Program.

"There's a lot at stake for hospitals. If they aren't providing good quality in all of these areas, they could have big problems," says

EXECUTIVE SUMMARY

A significant portion of the Centers for Medicare & Medicaid Services (CMS) 2015 Inpatient Prospective Payment System final rule focuses on quality and raises the percentage of the Medicare base payment hospitals can lose if they perform poorly.

- Case managers must be involved with patients from the minute they come in the door, through the hospital stay, and after discharge, experts say.
- Reimbursement is affected by risk-adjustment, which means case managers must make sure the documentation is as complete and specific as possible to show the full picture of the patient's severity of illness as well as any conditions that were present on admission.
- As the readmission reduction program expands to add new diagnoses and the penalties for poor performance increase, case managers must change their focus from discharge planning to transition planning that takes into account what resources patients need after discharge, experts say.

Linda Sallee, RN, MS, CMAC, ACM, IQCI, director for Huron Healthcare, with headquarters in Chicago.

In the final rule, CMS added chronic obstructive pulmonary disease and total knee and hip arthroplasty to the Hospital Readmission Reduction Program and proposed adding readmissions for coronary artery bypass graft to the program in fiscal 2017. Readmissions for myocardial infarction, heart failure, and pneumonia have been in the program since it began in 2012. Beginning Oct. 1, 2014, hospitals can lose up to 3% of reimbursement for every Medicare admission.

In fiscal 2014, hospital payments will automatically be reduced by 1.5% to fund the CMS Value-based Purchasing Program. CMS estimates that $1.4 billion will be dispersed to hospitals based on how well they perform on the value-based purchasing metrics.

In the first year of CMS's hospital-acquired conditions payment reduction program, the 25% of hospitals that perform most poorly will lose 1% of their Medicare base payment.

All hospitals are already losing a portion of reimbursement on individual cases when patients acquire targeted conditions during the hospital stay, says **Susan Wallace**, MEd, RHIA, CCS, CDIP, CCDS, director of inpatient compliance for Administrative Consultant Services, a Shawnee, OK-based healthcare consulting firm. Now, the poorest-performing hospitals will also lose 1% of reimbursement on all Medicare discharges, she adds.

In 2015, 35% of a hospital's score will be based on the Patient Safety Indicator 90, a composite of eight measures. The remaining 65% will be based on two healthcare-associated infection measures: central line-associated bloodstream infections and catheter-associated urinary tract infections. CMS proposed adding surgical-site infections to the program in 2016.

Quality rather than quantity

"CMS is moving steadily toward reimbursing hospitals for quality rather than quantity. Case managers have the potential to impact their hospital's bottom line by ensuring that patients have an effective discharge plan, and collaborating with other providers across the continuum of care," says **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services.

"With its quality initiatives, CMS is not rewarding good quality as much as it is punishing poor quality. The quality programs are punitive rather than incentivizing hospitals to improve. Hospitals have to focus on quality to avoid penalties," says **Thomas McCarter**, MD, FACP, chief clinical officer at Executive Health Resources, a Newtown Square, PA, healthcare consulting firm.

Hospital Case Management™ (ISSN# 1087-0652) is published monthly by AHC Media LLC, One Atlanta Plaza, 950 East Paces Ferry Road NE, Suite 2850, Atlanta, GA 30326. Telephone: (404) 262-7436. Website: www.ahcmedia.com. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Case Management™, P.O. Box 550669, Atlanta, GA 30355.

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Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

Subscription rates: U.S.A., **Print:** 1 year (12 issues) with free Nursing Contact Hours or CMCC clock hours, $519. Add $19.99 for shipping & handling. **Online only, single user:** 1 year with free Nursing Contact Hours or CMCC clock hours, $469. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Back issues, when available, are $78 each.(GST registration number R128870672.)

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This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 18 clock hours.

The target audience for Hospital Case Management™ is hospital-based case managers. This activity is valid 24 months from the date of publication.

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CMS's emphasis on quality means that case managers need to be involved from the time patients are admitted and throughout the entire stay, making sure that everything is documented, he adds. "The more you can document, the more correct the claim will be and the better the record will support it," McCarter says.

Medicare requires that all conditions be documented on every admission and that complications and comorbidities or major complications and comorbidities be considered for risk-adjustment purposes, he says. For instance, if a patient has diabetes, it should be noted in the documentation even if the patient is hospitalized for an entirely different reason.

"A hospital's overall reimbursement can be incredibly impacted by risk adjustment. It's imperative that all the patient's conditions and services received are documented and that the documentation is as complete and specific as possible to show the full picture of the patient's severity of illness as well as any conditions that were present on admission," Hale says.

It's going to take a team approach for hospitals to do well on quality measures, Sallee says. "Case management is not just utilization review and discharge planning but it is coordination of care, and this is more important as CMS moves toward value-based purchasing. Coordination and collaboration between disciplines is going to be key," she says.

Case managers are the common denominator while patients are in the hospital, Sallee says. "Doctors write the orders, but they aren't there to see that they are carried out in a timely fashion. Patients may have a different nurse every day, but the same case manager covers that unit," she says.

Case managers need to change their focus from discharge planning to transition planning that takes into account what resources the patients need when they go back to the community, Sallee says. They need to spend time with patients to find out their support system at home and assess them for risk of readmissions.

"A lot of readmissions occur due to social issues because patients didn't have access to what they needed after discharge. Case managers and social workers have a huge responsibility to develop appropriate transition plans that include helping patients tap into whatever community resources they need," Sallee says.

In value-based purchasing, the measurement period is well in advance of the payment period. For instance, performance periods for some measures that will be included in the program in fiscal 2019 and 2020 are starting soon, Wallace says.

This means hospitals can't wait until CMS adds measures to value-based purchasing to improve quality and impact their scores, she adds.

Instead, she advises case managers to look at the measures in the Hospital Inpatient Quality Reporting Program for clues as to what is likely to be included in value-based purchasing in the future since nothing can be included in value-based purchasing until it is part of the quality reporting measures. ■

Bundled payments: A glimpse into the future?

CMS is testing lump-sum payments

As part of the move to base reimbursement on quality, the Centers for Medicare & Medicaid Services (CMS) has launched the Bundled Payments for Care Improvement initiative, a three-year pilot program that provides a fixed price for a wide range of health services over a period of time.

Bundled Payments for Care Improvement pay a fixed price or lump sum for health services by multiple providers over a specified period of

EXECUTIVE SUMMARY

As part of its mission to cut costs and improve quality, the Centers for Medicare & Medicaid Services (CMS) has launched a pilot project that pays a fixed price for health services by multiple providers over a period of time.

- Case managers need to make sure that the care patients receive in the hospital is appropriate and can't be provided in another, less costly and less restrictive setting.
- Hospitals are going to have to evaluate their current practice patterns to identify potential areas for improvement and adopt the most efficient practices.
- Case managers must have accurate information about patients and their benefits to create the most appropriate and cost-effective discharge plan.

time or episode of care, explains **Karen Zander**, RN, MS, CMAC, FAAN, president and co-owner of the Center for Case Management. "For hospital case managers, this means that cost and utilization per case will replace length of stay as a primary goal," she says.

With the bundled payments initiative, CMS is moving toward giving hospitals lump sums to cover the entire episode of care. CMS wants to test payment and service delivery models that can potentially cut costs and still maintain quality, says **Linda Sallee**, RN, MS, CMAC, ACM, IQCI, director for Huron Healthcare, with headquarters in Chicago.

"The bundled payment pilots are just that, pilots, but CMS has indicated that it is looking for ways to improve the cost of care. The purpose of the CMS Innovation Center, as I understand it, is to develop solutions to the current healthcare issues and conduct trials of those solutions," Sallee says.

The Bundled Payments for Care Improvement initiative was developed by the CMS Innovation Center, which was created by the Affordable Care Act. The project began in April 2013, with more participants coming on board in January 2014. More than 230 acute care hospitals, skilled nursing homes, physician group practices, long-term care hospitals, and home health agencies have entered into agreements to participate in the Bundled Payments for Care Improvement initiative. Participants can choose from four models and a list of 48 different clinical episodes of care on which to focus. According to CMS, the 48 episodes of care represent 70% of Medicare spending.

"Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals, and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged," according to a CMS press release.

Pilot tests fixed payments for episodes of care

In the Bundled Payments for Care Improvement, the Centers for Medicare & Medicaid Services is testing four models that pay providers across a variety of settings a lump sum for an episode of care.

In Models 1, 2, and 3 in the pilot, CMS and the providers set a target price and payment amount for a defined episode of care for selected diagnoses, says **Karen Zander**, RN, MS, CMAC, FAAN, president and co-owner of the Center for Case Management. Providers are paid on a fee-for-service basis but at a negotiated discount. At the end of the pilot, total payments will be compared to the target prices and participants will share in the savings.

In Model 4, CMS makes a single bundled payment to the hospital to cover all part A and B services, including the hospital and physicians and other providers, and any readmissions. In this model, physicians and other providers submit "no pay" claims and are paid by the hospital, she adds.

Here's a look at the four models:

- Model 1 includes all acute care patients and all DRGs and pays hospitals a discounted amount based on the regular DRG rate. Medicare will pay physicians separately. CMS will share any cost savings due to better coordination of care with hospitals and physicians.
- Model 2 covers selected DRGs and includes all non-hospice Medicare Part A and B services during the initial inpatient stay plus the post-acute services for 30, 60, or 90 days depending on the DRG, and any readmissions. Laboratory services, durable medical equipment, prosthetics, orthotics and supplies, and Part B drugs are included.
- In Model 3, the episode of care is triggered by an acute hospital stay and begins when the patient begins receiving post-acute services at a participating skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, or home health agency. The model covers only the post-acute period for selected DRGs and includes any non-hospice Part A and B services, such as laboratory services, durable medical equipment, prosthetics, orthotics and supplies, and Part B drugs for only the post-acute period and any readmissions.
- Model 4 covers all services furnished during the inpatient stay by the hospital, physicians, and other practitioners as well as any services furnished when patients are readmitted for the same diagnosis within 30 days of discharge. ■

The bundled payment initiatives mean that hospitals must become extremely efficient and focus on reducing costs and improving quality, Sallee says. Case managers should work with physicians to make sure that the care patients receive in the hospital is appropriate and can't be provided in another, less costly and less restrictive setting, Sallee says.

The role of case management

"Case managers must be involved in their hospitals' efforts to analyze costs to determine the most cost-effective care and develop pathways or order sets to manage patients in an efficient manner. If services that are high-cost don't provide better outcomes, the hospitals will have to look at doing something different," she says. For instance, some physicians order services or post-acute venues that cost more than what other physicians order but do not necessarily result in better outcomes, she points out.

"Using evidence-based research to determine standards of practice and expected outcomes and managing variations within those standards will be crucial," Sallee says.

Case managers are going to have to master the ability to negotiate and advocate for patients who need the lower and less restrictive levels of care but have limited benefits. "In bundled payments, it will be necessary to ensure the agreements with post-acute providers will allow patients to move to the lower level of care when it is appropriate without the delays that are often common in the current environment," Sallee says. For instance, some nursing homes do not accept patients on the weekend or in the evening, she adds.

Hospitals are going to have to evaluate their current practice patterns to identify potential areas for improvement, Zander adds.

"In order to survive in today's healthcare world, hospitals need to understand the major cost drivers for care and develop predictive care paths that replicate the most efficient clinical decisions across the care continuum. In order to do this, hospitals have to have real-time reporting, monitoring, and accountability for utilization, outcomes, and demonstrating value," she says.

The bundled payment initiatives mean that case managers must have accurate information about the patients and what benefits they have immediately after admission, Zander says. They have to be familiar with the costs and outcomes of post-acute providers and be able to identify the most appropriate and cost-effective setting for their patients, she adds.

She points out that the choice of post-acute care settings can have a major impact on patient costs over a 30-day period. A readmission can more than double the episode cost, she adds. "According to the data I have reviewed, patients discharged to skilled nursing facilities have the highest readmission rates across all conditions. But the highest percent of readmissions comes from patients who did not receive post-acute care. Therefore, as we always have, case management professionals will need to continue to find that tricky balance between costs (including out-of-pocket costs to the patient) and quality of care," Zander says. ■

IPPS doesn't change two-midnight rule

Hospitals still must follow the regulation

The Centers for Medicare & Medicaid Services (CMS) did not clarify the controversial two-midnight rule in the Inpatient Prospective Payment System final rule for 2015 but may issue clarifications in sub-regulatory guidance later in the year or early next year, says **Thomas McCarter**, MD, FACP, chief clini-

EXECUTIVE SUMMARY

Although the Centers for Medicare & Medicaid Services (CMS) asked for suggestions on alternative methods of identifying and paying for short hospital stays, the agency did not clarify the two-midnight rule in the Inpatient Prospective Payment System final rule for 2015.

- CMS may issue sub-regulatory guidance to clarify the two-midnight rule later this year or early next year. Hospitals need to stay on top of CMS messages to avoid being blindsided by new rules.
- Meanwhile, the Medicare Administrative Contractors (MACs) are continuing Probe and Educate audits, and some have denial rates of 75%.
- Most of the claims were denied because of lack of medical necessity, lack of a physician signature, or because physicians did not document an expected length of stay.

cal officer at Executive Health Resources, a Newtown Square, PA, healthcare consulting firm.

The two-midnight rule was a major change in the 2014 IPPS, McCarter points out. "In the 2015 proposed rule, CMS suggested that it was looking for alternative methods of identifying short stays and paying for short stays but didn't put forth a proposal in the final rule. There has been no change in the two-midnight rule. We'll see the clarifications either in next year's rulemaking or in sub-regulatory guidance," McCarter says.

In the IPPS proposed rule, issued in April, CMS asked for suggestions on how to change the two-midnight rule to cover short stays. Here is a quote from the IPPS final rule:

"We thank commenters for the many comments submitted on this issue, and we will take these into account in any potential future rulemaking. Although there was no consensus among the commenters, we look forward to continuing to actively work with stakeholders to address the complex question of how to further improve payment policy for short inpatient hospital stays."

CMS frequently issues sub-regulatory guidance to clarify existing regulations, and sometimes it has a major impact, McCarter says.

For instance, on August 8, CMS issued Transmittal 534, which allows the Medicare Administrative Contractors to deny other claims, such as attending physician or surgeon's fees related to a hospital stay if the hospital stay is denied. "This is a huge change that allows auditors to deny payment to physicians without requiring any documentation or even notifying the physician that the claim is under review," McCarter says.

Hospitals must have a process to stay on top of the messages that CMS issues to clarify or change its regulations to avoid being blindsided when the new regulations go into effect, says **Steven Greenspan**, JD, LLM, vice president of regulatory affairs for Executive Health Resources.

Meanwhile, the two-midnight rule continues to be in effect.

"Many people in the healthcare field believe that the provisions of the two-midnight rule have been delayed, but that's not the case. There has been a tremendous amount of push-back from hospitals about the two-midnight rule and a lot of argument that it is not a fair approach, but hospitals still have to follow the policies outlined in the 2014 final rule," says **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services, a Shawnee, OK, healthcare consulting firm.

The Recovery Auditors won't be able to review compliance with the two-midnight rule until Oct. 1, 2015, but the Medicare Administrative Contractors are conducting pre-payment audits under the Probe and Educate initiative, she adds.

In addition to the MACs, the Zoned Program Integrity Auditors (ZPICS), charged with looking for fraud and abuse, are also auditing two-midnight cases. "There are a lot of auditors out there, and they are doing a lot of business," McCarter says.

The initial Probe and Educate audits are winding down, McCarter says. However, MACs can escalate the audits for hospitals that have claims errors. If the problem persists, the MAC will repeat the audit and will request 10 times the original number of charts, or 100 charts for small hospitals and 250 charts for larger hospitals. "Based on the published MAC denial rates to date, most hospitals will be escalated to higher audit numbers," McCarter adds.

"We are seeing MACs with denial rates as high as 75% when they audit under Probe and Educate. This means that providers and MACs are disagreeing 75% of the time on what the two-midnight rule means. That's a significant number of denials," Greenspan says.

Most denials are based on medical necessity, McCarter says. "The MACs are saying that the documentation did not support the need for an inpatient level of care and that the services should have been provided on an outpatient basis," he adds.

"In this new world of healthcare, hospitals need to answer two questions to comply with the two-midnight rule: Does the physician have a reasonable expectation of a two-midnight stay, and are the services being provided medically necessary," Greenspan says.

There has been a tremendous number of denials because the physician order to admit as inpatient was not signed prior to discharge or the physician did not explain that the patient improved more quickly than expected, resulting in a one-midnight stay rather than the expected two midnights, Hale says.

"The MACs have been very rigid. In some instances, the MACs were wrong in denying the claims and CMS has asked the MACs to look back at the denials of cases reviewed early on. Hospitals should continue to appeal the denials if they believe the MAC is wrong," Hale says. ■

Program helps at-risk patients stay healthy

Team contacts patients at least once a week

In the first eight months of the Advanced Illness Management (AIM) program at Carolinas HealthCare System, the 61 patients who received frequent and intense interventions from the AIM team experienced a 70% reduction in hospital admissions based on their readmissions for a similar time period before the program began.

The AIM program is staffed by five LPNs, two social workers, an RN, and a nurse practitioner. Each team includes an LPN, one of the social workers, the RN, and the nurse practitioner. The LPN is the primary contact for patients. The other clinicians join the teams as needed.

The program, which began in December 2013, targets patients who have multiple health issues that put them in the top 5% of healthcare utilizers, says **Deana Williams**, MBA/MHA, director of advanced illness management in the continuing care division for the healthcare system, which includes more than 900 care locations throughout North Carolina, South Carolina, and Georgia, including academic medical centers, hospitals, physician practices, post-acute facilities, home health agencies, and hospice services. With a total of 7,460 acute care and post-acute beds, Carolinas HealthCare System is the second largest public healthcare system in the country.

Before beginning the initiative, hospitals across the system looked at the continuum of care to develop strategies for coordinating care to ensure a smooth hand-off as patients move between levels of care, says **Kathleen Kaney**, DrPH, MBA, FACHE, senior vice president of system care coordination for Carolinas HealthCare System.

"We determined that we need to focus on a patient-by-patient level and work with at-risk patients where they really are. Educating patients on their medication regimen, helping them navigate the healthcare system, and connecting them with the correct physicians has been a big focus, and it ties in with our overall goal of providing and coordinating quality care efficiently and effectively as patients move across the continuum," she says.

The health system analyzes its medical records to identify patients at all participating hospitals who have been hospitalized twice in a six-month period or who have been to the emergency department three times in six months and who take multiple medications for chronic conditions. The AIM team reviews the records of referred patients and determines who could benefit most from the program.

"They work with patients with multiple needs and who require complex care coordination," Kaney says.

Typical patients in the program have a condition that puts them at risk, multiple comorbidities and are taking multiple medications, usually eight or more and sometimes as many as 30, Kaney says.

When a patient is identified for the program, members of the AIM team visit them in the hospital, explain the program, and ask if they would like to participate. The LPN and social worker check on the patients during the hospital stay and collaborate with the case manager on the floor to make sure the patient's discharge needs are met. After discharge, the LPN, RN, and social worker make a home visit for an assessment that may last as long as an hour and a half, Williams says.

They go over the discharge plan with the patients and educate them on managing their illness and following the treatment plan. They make

EXECUTIVE SUMMARY

At Carolinas HealthCare System, an Advanced Illness Management (AIM) team targets patients with multiple health issues and frequent hospitalizations and emergency department visits.

- The program is staffed by five LPNs, two social workers, one RN, and one nurse practitioner who work with patients in many hospitals in the system.
- Members of the AIM team visit eligible patients in the hospital, explain the program, and ask if they would like to participate. After discharge, the LPN, RN, and social worker conduct an assessment in the home.
- Patients stay in the AIM program until they transfer to another point of care, such as a skilled nursing facility, or they no longer need the services.

sure the patients have gotten their prescriptions filled and understand how to take their medication. They review the patients' medication and conduct medication reconciliation. The team also makes a thorough home assessment to identify safety issues and determine if the patients need any community resources and, if so, help them apply for the services, Williams says.

After the initial visit, the LPN contacts the patient at least once a week and reminds them when they have a physician appointment and helps them arrange transportation if needed. If the patient prefers, a team member will go with them to see their physician. "The LPN is the main point of contact. If patients need something or have a concern, they call the LPN, who may refer them to other team members for assistance," Williams says.

The program is patient-centered, and the interventions and education vary based on what patients need and what patients want, Kaney says.

"Relationship-building is a big key to the success of the program. The LPNs get to know the patients, their conditions, medications, their understanding of the treatment plan, and their needs. They learn about the patients' family dynamics, their past fears, and their hopes," she adds.

Over time, the LPNs build trust with the patients and their family members and often are able to get information that the patients ordinarily might not share.

"When people are this sick, it's not just the patients who need assistance. The family who help care for them often are concerned about how to manage the medication and other needs. The LPNs help the families learn whatever needs to be done. As the relationship develops, the patients realize we care about them and their families," Williams says.

Patients stay in the AIM program until they transfer to another point of care, such as a skilled nursing facility, or they no longer need the services. When patients move to a different level of care, the AIM team works with clinicians at the receiving facility to get them up to speed on the patient's conditions and issues and to ensure a smooth transition.

"The whole goal is not to ever lose a patient, to stay connected to them and ensure a smooth transition if they go to another level of care," Kaney says. ■

CM redesign breaks down barriers

Initiative sets role expectations

To function more efficiently in today's healthcare environment, the case management department at OSF Saint Francis Medical Center in Peoria, IL, underwent a comprehensive redesign that sets out clear role expectations, developed outcome and accountability measures, and promotes a proactive approach to patient transitions.

"When we began the restructuring project in 2011, we had significant resources in place, but we were not getting the outcomes we wanted. With the Centers for Medicare & Medicaid Services penalizing hospitals for excess readmissions and the beginning of value-based purchasing, we knew we had to figure out how to improve or restructure the department," says **Jane Counterman**, RN, manager, care management.

At the time, the case management department had patient care facilitators, discharge planners, social workers, and designated utilization review nurses but provided slim coverage on weekends, Counterman says.

The new structure was designed by a multidisciplinary team that analyzed the case department and determined that a big part of the problem was the lack of expectation for each role, says **Leslie Foti**, RN, BSN, supervisor for transitions and outcomes.

"There was a lot of crossover among the tasks that the patient care facilitators and the discharge planners were doing. The work of the discharge planners was largely reactive and driven by consultations," she says.

The members of the redesign team realized that they needed to develop clear role expectations, accountability measures, and consistency in what was being addressed on each unit.

In the new structure, the many facets of the roles of the discharge planner and the patient care facilitator were combined to create the role of care transition coordinator.

The redesign team created the new role of complex discharge planner, an RN who handles complicated discharges. They added a new job, case management assistant, who provides clerical support for the care transition coordinators, the complex discharge planners, utilization review

nurses, and social workers. The social worker and utilization review nurse role did not change.

The care transition coordinators are responsible for care coordination, length-of-stay management, simple discharge planning, patient care conferences, and for calling patients after discharge. They also assess and coordinate care for patients receiving observation services. "When patients are in observation status, we talk with the physician daily to determine if they need to be admitted or, if not, what they need to move on," Foti says.

Each care transition coordinator is also responsible for performing a chart review on two readmissions each week to determine why they occurred. "This arrangement has built-in accountability. It helps the coordinators identify areas where the discharge plan failed and make changes accordingly," Foti says.

In the original structure, there was one manager over utilization review and patient care facilitation and a separate manager for social work and discharge planning.

Under the new structure, there is one department manager, along with five frontline supervisors for care transitions, one for social work, and one for utilization review. The frontline supervisors work two days on the floor and three days as a supervisor.

For example, Foti is a care transition coordinator for two days a week and a supervisor for the rest of the care transition coordinators in her zone of the hospital for the rest of the week. "This gives the supervisors the big picture. They can see firsthand what is happening, and it helps them break down bigger barriers," she says.

Prior to the restructure, two discharge planners worked on weekends and covered all 600 beds. After the restructure, the team divided the hospital into five zones, and one care transition coordinator from each zone covers the weekends on a rotating basis. A complex discharge planner works on Saturday. The supervisor covers the shifts when the care transition coordinator is assigned to weekend duty.

"Because I am also working on the floor, I can provide real-time feedback to the staff. In essence, I am auditing people every time I cover their shifts," she says.

The goal under the new structure is for case managers to see every patient and complete an initial assessment on Day 1 and to discuss all observation patients with providers each day.

The assessment identifies early on what kind of support the patient is going to need after discharge and the payer source. "We start asking the physician ahead of time if the patient will need home health or outpatient treatment so we can have everything in place when the patient is ready for discharge," she says.

The team standardized the format the care management team uses to make notes in the record so it's consistent on all units. "The notes in the electronic medical record cover the same topics in the same order. This way the case management staff knows where to look in everybody's notes to find the information they need," she says.

For instance, the first items in the notes identify the primary problem, the anticipated length of stay, goals, and barriers to discharge. There is a place for information about the home situation, who will provide support after discharge, and the patient's prior level of functionality, she says.

"At first, the staff found the format constrictive, but they have come to appreciate the consistency. Now when a patient is moved from the step down unit to the medical/surgical unit, the care coordinators who are receiving the patients know where to look in the notes to find the information they need," she says.

The redesign focused on breaking down barriers, Counterman says. For instance, in the previous structure, each of the two managers were responsible for about 50 employees each. Now with fewer employees to manage, the managers have the flexibility to work on any trends and

EXECUTIVE SUMMARY

OSF Saint Francis Medical Center in Peoria, IL, redesigned its case management department to improve efficiency and clearly define the role of each clinician.

- The redesign combined the roles of discharge planner and the patient care facilitator to create the role of care transition coordinator, created a new role of complex discharge planner, and added clerical support to the department.
- The restructure divided the hospital into five zones, and one care transition coordinator from each zone covers the weekends on a rotating basis. A complex discharge planner works on Saturday.
- The format the care management team uses to make notes in the records was standardized so it's consistent on all units.

barriers they identify and can escalate a response a lot faster, she says.

For instance, if there are new regulations from payers, the frontline supervisor can huddle with the team, inform them of the changes, and answer questions. "In healthcare today, regulations and rules change quickly. Email is a great way to communicate, but it doesn't give employees the opportunity to learn from other employees' questions," she says.

Foti calls case managers "the special ops of healthcare. We catch the first wave of new regulations and other challenges. Not a single day goes by without somebody asking us to do something challenging and we make it happen," she says. ■

CDC: Be alert for Ebola signs in African travelers

Two U.S. HCWs develop symptoms of virus

U.S. public health authorities urged health providers to raise their awareness about Ebola virus as two American health care workers became ill with the often fatal disease while caring for infected patients in Liberia. At about the same time, a Liberian man became ill with Ebola and traveled by plane to Lagos, Nigeria, where he died in a hospital.

The Centers for Disease Control and Prevention issued a Health Advisory on July 28, asking U.S. health care providers to be alert for possible signs of Ebola and to isolate patients who have Ebola-like symptoms and have traveled to a country with Ebola cases within the past 21 days. (http://emergency.cdc.gov/han/han00363.asp) The initial symptoms of Ebola are flu-like, with fever and aches accompanied by vomiting and diarrhea.

At mid-summer, the largest Ebola outbreak in history had reached more than 1,200 cases and 672 deaths in Guinea, Sierra Leone and Liberia. As of late July, it had not appeared outside of West Africa.

Ebola is transmitted through contact with blood and body fluids but is not thought to be airborne. CDC recommends standard, contact and droplet precautions, which means health care workers must wear gloves, gowns, face masks and eye goggles or shields.

Yet because Ebola has a fatality rate as high as 90%, health care workers often wear heavy-duty fluid-resistant suits.

Stephan Monroe, deputy director of CDC's National Center for Emerging Zoonotic and Infectious Diseases, noted that clinics in Africa have "rudimentary" equipment. Exposure can occur through needlesticks or other exposures as health care workers collect specimens or dispose of bodily fluids, he said in a telephone press conference.

In recent years, the United States and the Netherlands each treated a patient who contracted Marburg hemorrhagic virus, which is similar to Ebola. No one else became infected, Monroe said.

"In both of those cases, the patients presented to the healthcare system before it was identified they had the virus infection, but they were treated with standard barrier nursing and infection control practices in the hospital," he said. "In neither case was there any evidence of health care-associated transmission in those settings."

The bottom line: The hospital environment is much safer in the United States than in Africa. "While it's clear there is an increased risk for working with patients with Ebola, we're confident that the standard of care in the U.S. would prevent much of the transmission," he said.

Nonetheless, there is always danger from an undiagnosed case. Health providers, particularly in emergency departments, need to be aware of global outbreaks and their potential to spread, Monroe said. "The point is to raise the level of awareness in emergency rooms and all of the front line places for primary care," he said. ■

Quick facts on Ebola

According to the Centers for Disease Control and Prevention, Ebola symptoms, infectious fluids and transmission factors include the following key points:

Symptoms: Sudden onset of fever and malaise, with other nonspecific symptoms such as myalgia, headache, vomiting, and diarrhea. In later stages of the disease, patients may develop multi-organ dysfunction, including hepatic damage, renal failure, and central nervous system involvement,

leading to shock and death.

Infectious fluids: In an infected person, the Ebola virus may be present in blood, urine, sweat, semen, and breast milk.

Transmission: Ebola is spread through direct contact with the bodily fluids of someone who is symptomatic. The incubation period is usually eight to 10 days, but has had a range of two to 21 days. Transmission can occur when a patient is febrile and throughout the course of the disease, including post-mortem. ■

On-again, off-again ICD-10 is on again

Implementation starts Oct. 1, 2015

The Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) now say that Oct. 1, 2015, is the new compliance date for healthcare providers, health plans, and healthcare clearinghouses to start using ICD-10.

Implementation of ICD-10 was scheduled for Oct. 1, 2013, but HHS postponed it for a year to give providers more time to prepare. But just six months before the Oct. 1, 2014, deadline, Congress delayed implementation again as part of a bill to postpone cuts to Medicare physician payments.

The new deadline means that all claims submitted on or after Oct. 1, 2015, to any payer covered by the Health Insurance Portability and Accountability Act (HIPAA) for services provided in all healthcare settings, must use the ICD-10 codes for medical diagnoses and inpatient procedures. Otherwise, the claims may be rejected and providers will have to resubmit them using the ICD-10 codes. ■

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4. After successfully completing the test, 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. ■

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

■ Clinical pathways are gaining favor again.

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■ Strategies for improving transitions to SNFs.

■ Helping patients make informed decisions.

CNE QUESTIONS

1. In the first year of the Centers for Medicare & Medicaid Services' hospital-acquired conditions payment reduction program, what percentage of their Medicare base payment will the 25% poorest performing hospitals lose?
   A. 1%
   B. 1.5%
   C. 3%
   D. 5.5%

2. According to Linda Sallee, RN, MS, CMAC, ACM, IQCI, director for Huron Healthcare, with the bundled payments initiative CMS is moving toward giving hospitals lump sums to cover the entire episode of care.
   A. True
   B. False

3. What reasons are the Medicare Administrative Contractors giving for denials under the Probe and Educate initiative?
   A. The documentation does not support the need for an inpatient level of care.
   B. The physician did not sign the order to admit prior to discharge.
   C. The physician did not explain that the patient improved more quickly than expected, resulting in a one-midnight stay rather than the expected two midnights.
   D. All of the above.

4. How long does the Advanced Illness Management (AIM) program at Carolinas HealthCare System coordinate care for patients at high risk for readmissions?
   A. Six months after discharge.
   B. Sixty days after discharge.
   C. One year after discharge.
   D. Until they transfer to another point of care or no longer need the service.

Hospital Report blog

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