HOSPITAL CASE MANAGEMENT™

the monthly update on hospital-based care planning and critical paths

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

Financial Disclosure:
Managing Editor Russ Underwood, Editorial Group Head Coles McKagen, and Editor Mary Booth Thomas report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Toni Cesta discloses that she is principal of Case Manager Solutions LLC.

AUGUST 2006
VOL. 14, NO. 8 • (pages 113-128)

Whether it's transportation or post-acute care, rural CMs rise to the challenge

Thinking outside the box is critical for success

Case managers in rural hospitals have to think outside the box and find creative solutions to problems that their big city counterparts rarely face.

Their patients often live a long distance from the hospital and may not have transportation home or anyone to take care of them once they get home. Specialty services are hundreds of miles away.

In many small towns, taxi and bus service isn't available, and even if it were, some patients can't afford it.

"Sometimes just getting somebody home from the hospital is a challenge. We have to use our imaginations and be resourceful to meet the patient's needs," says **Ann Jacobsen**, RN, case manager at Clinton Regional Hospital in Clinton, OK. The hospital includes 40 beds for acute care patients, four beds in the intensive care unit, and the 10-bed Jim Thorpe Rehabilitation Unit.

When a patient needs transportation home and doesn't have relatives nearby, she gets on the telephone and calls anyone who comes to mind.

"I just go by the seat of my pants and keep calling until somebody

CMS proposes sweeping changes in hospital payment structure

New rule would require more attention to documentation

The Centers for Medicare & Medicaid Services has proposed sweeping changes to the payment structure for hospitals, including the first significant revision of the Inpatient Prospective Payment System (IPPS) since it was implemented in 1983.

*(See **CMS**, continued on page 123)*

says they'll drive the patient home," Jacobsen says.

For instance, there are elderly patients who need to go to Oklahoma City, 87 miles away, for specialty care but don't qualify for an ambulance.

If the patient's only relatives are elderly and don't want to drive on I-40 or face Oklahoma City traffic, Jacobsen contacts neighbors and local churches.

Then there's the dilemma of people who have been injured in an accident on I-40 and totaled their car or damaged it so much it's not drivable. The closest car rental facility is in Oklahoma City.

"Sometimes, people who are in the hospital visiting their relatives overhear me talking on the telephone and offer to take people home. This is a wonderful little town of about 8,000 people, and everybody pitches in to help their neighbor," she says.

"Being a case manager in a rural hospital makes you think a little harder. When situations come up and I don't know what to do, I get on the phone. Sometimes it takes all day or longer to get one patient to Oklahoma City or to line up a discharge destination that the family likes," Jacobsen says.

Transportation is a challenge

Transportation is the biggest challenge for **Carol Wallace**, BSN, case manager at Mercy Regional Medical Center in Durango, CO, whose hospital serves a population that lives as far as 100 miles away. Albuquerque, NM, is the nearest big city, and it's 200 miles away. Denver is 320 miles away.

"We have to encourage patients to find their own transportation. We don't have the ability to get them home if they live 50 miles away. We encourage them to call on friends and family members to take them home," she says.

Buses from senior citizen centers bring elderly people to Durango from outlying communities for shopping and physician appointments, but they don't come every day and may not be an option for an elderly patient who is being discharged.

Patients who live in Durango and have no other transportation may have to take a taxi home.

If patients are acutely ill and need specialized care, the hospital has a contract with an aviation service to fly them to Denver or Albuquerque.

"We have a lot of patients who are transported to a hospital that can provide a higher level of care right out of the emergency room. We also transport patients to long-term acute care centers [LTACs] via helicopter or fixed-wing plane. Most of these patients are acute and may go to the LTAC for vent weaning," Wallace says.

There is one nursing home in Durango and several others 30 to 50 miles away. The closest rehabilitation facility is 50 miles away.

"We have to rely on family members to provide transportation for our patients, especially if they're going to the rehab facility or to one of the cities," she says.

Funding is sometimes an issue if a patient

Hospital Case Management™ (ISSN# 1087-0652), including **Critical Path Network**™, is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Case Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 Mon.-Thurs.; 8:30-4:30 Fri. EST. E-mail: ahc.customerservice@thomson.com. Web site: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $469. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $78 each. (GST registration number R128870672.)

Thomson American Health Consultants is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, provider number CEP 10864. This activity is approved for 18 contact hours. This activity is valid 36 months from the date of publication. This program is approved by the American Association of Critical-Care Nurses (AACN) for 14 contact hours. Provider (#10852).This activity is approved by the Commission for Case Manager Certification for 18 clock hours.

This activity is approved by the National Association of Social Workers for 18 contact hours.

Editorial Questions

For questions or comments, call **Russ Underwood** at (404) 262-5521.

Editor: **Mary Booth Thomas**, (marybootht@aol.com).
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@thomson.com).
Senior Production Editor: **Nancy McCreary**.

needs to go to a rehab center or nursing home, Wallace adds.

"If the patient is uninsured, the post-acute facilities won't accept them and we are obligated to keep the patient and provide ongoing care," she says.

Discharge planning

Finding a post-acute or rehab placement for patients who need to be discharged often means transferring the patient to another city, and in many cases, families balk at moving their loved ones that far from home.

For instance, at most of the rural hospitals in the Integris Rural Health, the closest long-term acute care facility is at least two hours away.

"The most challenging part of the job for me is to convince the spouse of an elderly patient that he or she can no longer provide care. Nobody wants to go to a nursing home, but we can't discharge a patient unless it's to a safe environment," adds **Gloria Ross**, MBA, RN, CPUM, case management director at Bass Baptist Hospital in Enid, OK.

Case managers have to be careful not to give the impression that the hospital is pushing the patient out the door or that their main focus is money, points out **Denise Caram**, MS, CPUM, CPUR, director of support services for Integris Rural Health, a system of eight rural hospitals with headquarters in Oklahoma City.

"We start talking to the family about discharge on Day 1 and start to educate them about finding a discharge destination where their family member will have the best long-term outcomes. We believe that if you develop the plan of care at the beginning of the stay, the patient and family understand that the quality of the care the patient receives is the most important thing," she says.

The case management staff must find post-acute placement for about a third of the patients admitted to Lake Granbury Medical Center in Granbury, TX, according to **Lyn Clark**, RN, BSN, director of case management.

"Finding a bed can be a challenge. People move here to be near mom and dad, and they don't want them to be in a nursing home that's an hour's drive, one way," she says.

The area has a large retirement community and just three small community nursing homes, making it necessary to refer patients to skilled nursing facilities in Fort Worth, about 50 miles away.

Bass Baptist Hospital occasionally has paid for patients and families to stay in a motel when the patient has to have radiation every day for six weeks and they live 200 miles away, Ross says.

"We have to use our ingenuity in making sure the patients get the care they need. We work with community agencies and vendors to help indigent patients. If a patient can't pay for his medication and isn't eligible for community programs, we ask physicians to provide samples," she adds.

The hospital has set up an apartment where a patient and his or her family members can live until the family is comfortable providing the care the patient needs after discharge.

"By teaching the families to take care of the patient in a homelike setting, we've been able to send some patients home with ventilators," Ross says.

At Clinton Regional, the average length of stay is 3.5 days, but some patients stay longer if there is no alternative. One recent patient had an eight-day length of stay because she couldn't go home alone and didn't meet the criteria to go to another level of care.

Terminally ill patients often have long lengths of stay when they can't go home but there's no place for them to go.

"The hardest thing for me is when a patient is dying and I know the family. I have to tell them the patient can't stay in the hospital and they don't understand why. They can't take care of the patient at home, and they don't want them to go to a nursing home," she says.

In rural settings, it's extremely important to develop a good relationship with family members, particularly if they live out of town, case managers say.

"We have elderly patients who live on a farm their family has owned for generations but their children have moved away. It's hard to send an elderly patient home if he lives by himself out in the country. I always try to develop a good rapport with family members so I can make sure the patient will get care after discharge," Jacobsen says.

Sometimes, Jacobsen calls her patients at home the night they are discharged to make sure they're OK, especially if home care doesn't start until the next day.

"We encourage patients and families to take a lot of responsibility for care after discharge. We try to bring the family in as much as possible to help with discharge planning. We don't have resources that are easily available. We can't just transport them across the city in an ambulance," Wallace says. ■

DP to fundraising: Rural case managers do it all

One-person departments do the work of many

A case manager in a rural setting often is responsible for what it takes an entire case management department to do in a big city hospital.

In addition to managing the care while the patient is in the hospital, they do all the discharge planning, making arrangements for medications, home health, durable medical equipment, or any other post-discharge needs, working with the insurance companies to get them approved.

They track quality measures, such as delays in treatment, avoidable days, and outliers.

"It's almost like trying to be an expert in a lot of different regulatory arenas," adds **Lyn Clark**, RN, BSN, case management director at Lake Granbury Medical Center in Granbury, TX.

Rural case managers must be familiar with what treatments Medicaid, Medicare, and commercial insurance will allow and what they will pay for them and must collaborate with the business office on financial issues.

"When a case manager is the only person on staff doing case management, he or she has to be involved with the financial aspects of care and how it can affect the bottom line of the hospital," says **Denise Caram**, MS, CPUM, CPUR, director of support services for Integris Rural Health, a system of eight rural hospitals with headquarters in Oklahoma City, OK.

CMs wear many hats

At Integris Rural Health, the case managers are in charge of utilization management along with the medical director, they sit on the hospital's quality committee, and sometimes are on the medical executive committee.

They are involved with the hospital foundations, working on fundraising efforts to provide funds for indigent patients.

Out of eight hospitals in the Integris system, six of them have only one case manager.

In addition to her duties as case management director at Bass Baptist Hospital, a 183-bed facility in Enid, OK, **Gloria Ross**, MBA, RN, CPUM, also is director of case management at the health system's children's behavioral health center, the skilled nursing facility, and the long-term acute care hospital (LTAC). She supervises a total of six case managers at the three facilities.

As the only case manager at the LTAC, she has to negotiate per diem rates with the insurance companies.

Ross spearheaded a fund drive for indigent patients who can't afford medication and frequently speaks to civic organizations on behalf of the hospital's foundation.

She meets with her hospital case management staff for 20 minutes every day and goes over their plans for the day.

"Some days, I feel like I can't get it all done. I have a lot of my plate, but my case managers know that I expect business as usual if I'm not on the floor. They know I'm just a beep away," Ross says.

When Clark became case management director at Lake Granbury Medical Center, it wasn't unusual for case managers to be asked to get blood from the blood bank, give a patient his or her medication, or even go to a patient's home and feed her cats.

"I've had doctors ask me to find patients jobs or apartments or to take their dog home with me. That's not my job, but I will plug them into community resources, and I can find someone who can call the ASPCA to find out if they'll feed the animals. Part of the role we play is to take the worry away from the patient. The doctor has known Mrs. Jones for years and knows she's worried about her cats," she says. **(For more on case management at Lake Granbury Medical Center, see related article, p. 117.)**

In a rural setting, case managers are asked to do myriad jobs that can be done by people with lower skill levels because nobody understands exactly what case managers do. If a case manager agrees to give medications or run errands once, the expectation is there that they'll do it over and over, Clark points out.

"When I came here, the nursing staff was used to having some additional hands and using case managers for inappropriate roles. We had to pull back and redefine the role and educate everyone in the facility. It has required a real change in the hospital culture," she says.

Clark advises case managers in small hospitals to help educate the hospital administration about the role of case managers and how they can help improve patient care and the hospital's bottom line.

"If they don't understand case management, they don't understand the benefits that case managers provide. They don't know the hoops that case managers have to go through with Medicare,

Medicaid, and commercial insurance," she points out.

Case managers in rural areas must work closely as a team with physicians and have support from the physicians and the hospital management.

Originally, Integris Rural Health's case management model included both RNs and social workers as case managers, but the model has evolved so that only RNs are case managers.

"We realized that physicians were more comfortable in talking about clinical issues with a clinical person. It was a challenge for social workers when they were handling discharge planning issues that required clinical knowledge," Caram says.

Since the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires that hospitals have a social worker, Integris has a social worker on contract who it can pull in when necessary or, if there is a home health agency or hospice in the network in that city, it utilizes that facility's social worker.

The case managers in many of the rural facilities call on the area's ministerial alliance to provide counseling if the hospital doesn't have a chaplain.

"The case managers are dealing every day with patients and physicians. A social worker can't write an order for a physician or take orders over the telephone. With the challenges we have, it's more feasible to have RNs and use others to pick up the social work piece," Caram says.

In a small town, everyone recognizes the case manager, and they don't hesitate to ask questions about advance directives, nursing home placement, and other concerns, says **Ann Jacobsen**, case manager at Clinton Regional Hospital in Clinton, OK.

"I do a lot of grocery store care management. It's not unusual for someone to call me at home and ask for advice about a particular doctor or whether their parent should go to Oklahoma City for care. It's all part of the job," she says. ■

Reorganization helps improve reimbursement

CMs ensure documentation, medical necessity

In the first year after reorganizing the case management department, Lake Granbury (TX) Medical Center, a 59-bed facility, substantially increased reimbursement by improving documentation and saved $35,000 by putting case managers in charge of getting Medicaid forms signed, rather than relying on an outside vendor.

"This is a small hospital without a cardiac or neurological unit, and we have to be careful with the resources we have and to make sure that everything is correctly documented and that we move every patient through the continuum as quickly and safely as possible," says **Lyn Clark**, RN, BSN, director of case management.

That hasn't always happened, says Clark, who was recruited in 2005 by the chief executive officer, who charged her with organizing the case management program.

She discovered a hospital with two case managers who were working without direction, often doing jobs, such as picking up blood from the blood bank, that could be done by staff with a much lower level of training.

The case managers were called on to help out the nursing staff by giving medications or seeing the patient at the bedside. "We have to focus on using our resources wisely. If we're not helping the facility to be financially solvent and the hospital closes its doors, we won't be serving anyone," Clark says.

Clark started by developing a training program for the case managers. "In a small town, you have to grow your own. People who have been nurses for 20 years are not necessarily good case managers. If someone has compassion, common sense, and has the ability to do critical thinking, they can learn the principles of case management," she says.

The hospital has two FTE case managers, split into three positions. Two of them work four days a week. The other works two days. Between them, they provide coverage seven days a week, 10 hours a day.

Clark has created educational modules to teach her case managers about Medicare and Medicaid rules and regulations, DRGs, case mix index, length of stay, and other information they need to do their jobs.

She continues to educate her staff regularly about changing regulations. "As case management director, my role is to digest and understand the new regulations and to feed it to my staff in increments," Clark explains.

The case managers received training on basic computer skills and learned to set up worksheets for tracking and trending instead of keeping data on pieces of paper.

"I had to get the staff to learn to think differently and to avoid duplication. You can be busy

and not be productive. They were doing a lot of busy work, like retyping reports to make them look good," Clark says.

When Clark started work at the hospital, she ran data on the hospital's DRGs for the previous 12 months. "We had an aging population and no cases of complex pneumonia. That was a clue that the documentation was not appropriate," she says.

When Clark pulled the charts on a sampling of patients, she found a lot of problems.

For instance, there was an 80-year-old whose record said she had simple pneumonia but who had underlying hypertension and diabetes and was being treated for both conditions while she was in the hospital.

"Nobody was here to point out to the doctor that the documentation had to reflect complex pneumonia in order for the facility to be paid. Once we began delving into the documentation, it was like peeling an onion. We uncovered layer after layer of issues," Clark says.

In one year, the hospital's case management staff substantially increased reimbursement by assuring that patients' conditions were appropriately documented.

"By appropriate documentation, we increased case mix index, and that added hundreds of thousands of dollars to our reimbursement," she says.

Clark worked with the case managers to make sure they reviewed all Medicare one-day stays daily and to ensure that patients on Medicare stay for the full DRG length of stay if they will be transferred to rehab.

Now the case managers work closely with the physicians to ensure that the documentation is sufficient so the hospital will be reimbursed.

"We inform the physician that we want the document to show a clear picture of the patient and the true severity of illness and that we can't expect a nonmedical person who does coding to make that leap. They don't have the background that a physician or a nurse does," Clark says.

The hospital saved $35,000 a year when the case managers assumed responsibility for getting Form 3038 signed as required by Medicaid for newborn infants, instead of paying an outside vendor to do it. "We were paying the vendor $400 a form and were able to show each month how much we saved," she recalls.

In the past, if patients came into the emergency department with no physician of record and couldn't afford medication, the hospital would admit them for 10 days and give them the antibiotics. "As case managers, we should know the community resources such as drug programs that give indigent patients access to antibiotics. Now, we get the patient their antibiotics and send them home," Clark says.

The case managers monitor improper admissions and inappropriate use of resources. "We save the hospital beds for the patients who truly need to be in that bed," she says.

When you are the first case manager at a small hospital, you may not feel very popular, Clark says.

"The doctors don't like you because you don't let their patients stay three weeks. The nurses think you're cruel to push for appropriate discharge for patients. The family members are mad because they want grandma to stay in the hospital to rest," she says.

Being a case manager in a rural setting often means that you're a lone wolf, Clark says. "The system didn't break overnight. It won't be fixed overnight. Often you have to think outside the box," she says. ■

Documentation program nets hospital $1 million

Coders work with CMs on documentation

A documentation improvement program in which care managers and coders work as a team resulted in an increase in revenue of more than $1 million in 2005 for United Health Service Hospital in Johnson City, NY.

"By making sure that everything is documented accurately, we're getting credit for what we're already doing. We're already giving the patients these services and supplies, but now we're documenting and coding it, and that results in more reimbursement," says **Nancy Rongo**, CNAA, BC, CHCQM, director of care management and medical social work.

Each day, two documentation enhancement coordinators, trained medical coding specialists, go to the hospital units and review the charts. They are assigned to specific units and work with the care managers on those units to ensure that the physicians are documenting the complexity and intensity of the services provided.

The coders are specialists in knowing what needs to be documented in order for the hospital

(Continued on page 123)

CRITICAL PATH NETWORK™

Hospitals getting more RFIs in 2006: What problems are surveyors finding?

New process is better at uncovering areas in need of improvement

Since the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) unannounced survey process began in January, the average number of requirements for improvement (RFIs) given to hospitals has increased to 6.9 as of April 2006, compared with 5.8 in 2005.

"It's not a huge difference, but RFIs have gone up, about one RFI increase per organization," says **Linda Murphy-Knoll**, vice president of service operations for JCAHO's division of accreditation and certification operations.

The trend could be due to the use of tracer methodology, which takes surveyors to the actual point of care with patients, and also the fact that surveys are now unannounced.

"It's obvious to everyone that we will find more, versus looking at policies and procedures in a room," says Murphy-Knoll. "I think that in the past two years, the surveyors have just gotten better at doing tracers and pulling threads. They find something, become interested in what they have found, ask more questions, and find more RFIs."

JCAHO's new process is part of the reason for the additional RFIs, says **Judy B. Courtemanche**, president and CEO of Courtemanche & Associates, a consulting firm specializing in regulatory compliance and outcomes management, based in Charlotte, NC. "There is the element of surprise, and the tracer process reveals process gaps more quickly than previous survey methodologies," she says.

Scoring also is more severe: Three instances will earn an RFI in most cases, but in some cases only one infraction with a required element of performance can generate an RFI.

"There are also increasing performance expectations from JCAHO," says Courtemanche. "An unrelenting emphasis on medication management continues to generate RFIs. There is also a JCAHO requirement that surveyors note findings regardless of potential scoring."

In addition, technology alerts JCAHO to areas in need of improvement, even if findings are not discovered by surveyors, notes Courtemanche. At the same time that JCAHO has better prepared surveyors with more intensive survey tools, organizations are struggling to keep up with the continual regulatory changes coming their way, she says.

"Preparing entire organizations to respond to the possible surveyor tracer has required unplanned resources of time and money just to stay afloat," she says. "Organizations that have always performed well are finding the new approach difficult to prepare for. The results are often an unexpected shock."

Leaders must change their approach to accreditation from a one-year ramp-up to adopting continual compliance strategies that render their organizations survey-ready at all times, says Courtemanche. "Organizational philosophies must embrace regulatory compliance as a basic operating tenet."

Health care professionals can advance this process by staying informed and keeping their leaders informed, she says. "Leaders do not want to hear that the new survey process is producing unexpected results and that they could lose their accreditation. Leaders want to hear how the organization can standardize its approach to assure

predictable outcomes," she says.

The RFIs are coming for medication reconciliation and other National Patient Safety Goals and Environment of Care (EOC) standards, according to **Susan Mellott**, PhD, RN, CLNC, CPHQ, FNAHQ, CEO of Houston-based Mellott & Associates, a consulting firm specializing in health care performance improvement. "With the advent of unannounced surveys, the hospitals cannot prepare for survey like they did before," she says.

It's important that new standards are implemented prior to the date they become effective, says Mellott. "They must be proactive rather than reactive. They must also have members of the facility do tracers every month to assure that the processes are working," she says.

Here are some trends in RFIs received by organizations in 2006:

• **Use of unauthorized abbreviations.** Organizations are required to identify a list of abbreviations they will not allow to be used in daily medication-related documentation, and at a minimum must use the JCAHO's list of nine abbreviations, although they can choose to add additional ones.

"What we are finding is that it is really a cultural barrier," says **Darlene Christiansen**, RN, LNHA, MBA, JCAHO's executive director for accreditation and certification operations. "Licensed independent practitioners who have been in practice for a number of years were taught to use certain abbreviations. It's a matter of reeducation and reinforcement about the reason behind this, which is safety for the patient, because there have been medical errors made and sentinel events that have occurred when those abbreviations were used."

Organizations have been receiving RFIs for failing to educate contractual employees about unauthorized abbreviations. "That can become challenging if there is a large group involved with a rotational schedule, but you have to work with the contractual service to develop an ongoing education plan," says Christiansen.

• **Medication reconciliation.** Although most organizations have a process for medication reconciliation, it's often not comprehensive enough, says Christiansen.

In 2005, organizations were only required to have developed a process to reconcile a patient's medications, but as of Jan. 1, 2006, surveyors are looking to see that the process actually has been implemented.

"It begins at the patient's point of entry into the organization, and continues on through the continuum of care," says Christiansen. "Each time the patient changes the level of care, medication reconciliation is critical."

The point of entry is the most critical and most challenging part of the process, whether the patient comes through the ED or direct admissions, says Christiansen. "You may have a nonresponsive patient without family members immediately available, which poses a big challenge for the caregiver who needs to provide medication."

Surveyors want to see that staff obtain a complete medication history, not only for prescription drugs, but over-the-counter and herbal medications as well.

"The difficult piece is to be more comprehensive," Christiansen says. "If the patient is able to contribute, you can get much of the history from the patient. But even then, you may have to prompt the patient with questions. A patient may forget to mention that they take aspirin every day or other over-the-counter medications."

• **Communication during patient hand-offs.** Surveyors want to see a process in place to ensure that caregivers communicate with each other with an opportunity to ask questions, when passing care on from one shift to another, or one care provider to another.

"We are not asking that the process be documented, but we want to ensure there is a process in place. When surveyors come through and do their tracer methodology they need to observe that process," says Christiansen.

• **Life safety code compliance.** A life safety code specialist is now present during surveys for hospitals with 200 or more licensed beds.

"So we are seeing an increased focus in EOC, and with that comes additional RFIs," says Christiansen.

"This has been a focus for JCAHO for the past four or five years, but the focus is now more intense. The EOC is a high-risk area for the patient population and for the staff internally," she says.

A common problem is that organizations having construction have not implemented the interim life safety code measures that are required, such as an increased number of fire drills. Another area is that when an organization brings in contract staff to do repairs or construction, they have not been educated on how to ensure patient and staff safety.

"When you are going through construction, you need to protect the patient from any infection control issues — you don't want debris or dust flying around. So education is important," says Christiansen.

• **Medication management.** This area is another

common cause of RFIs, including ordering, filling prescriptions, administration at the bedside, patient identification, verification of the right medication and dosage, and labeling medications.

"As we evaluated safety trends in patient care, the failure to label has indeed increased adverse outcomes to the patient population," says Christiansen. "It was common practice for anesthesiologists to not label medications, so again it was a reeducation that was needed."

The following RFI threshold changes were decided at a March 21 meeting of the JCAHO's accreditation committee and are retroactive to Jan. 1: For large hospitals with an average daily census equal to or greater than 100, it takes 14 RFIs to receive conditional status (up from 10), and 20 RFIs to receive preliminary denial of accreditation (up from 15). For small hospitals with average daily census less than 100, it takes 11 RFIs to receive conditional status (up from 10) and 16 to receive preliminary denial (up from 15). In 2005, 2.2% of hospitals were put on conditional accreditation.

The thresholds are simply a means for identifying organizations that need further scrutiny, says Murphy-Knoll. The JCAHO's board committee considers each organization separately and decides whether to apply the rules for conditional status or denial of accreditation, she explains.

"This is not decreasing the strength or credibility of the survey process. It's just being fair to organizations, assuring that they not be treated differently based on their size," she says. "It is definitely not a weakening of the accreditation process." In fact, based on the changes made in the last few years, the process has been strengthened significantly, says Murphy-Knoll. ■

IC group pushes for mandatory flu shots

Voluntary vaccine approach has failed, expert says

Voluntary annual influenza immunization programs that use educational efforts and other incentives to vaccinate health care workers have been an abject failure, a leading proponent of mandatory flu shots said recently in Tampa at the annual conference of the Association for Professionals in Infection Control and Epidemiology (APIC).

"We have to acknowledge that voluntary immunization programs have never resulted in high immunization rates in any setting for any age at any time for any reason at any location with any vaccine," said **Gregory D. Poland**, MD, director of the vaccine research group at the Mayo Clinic in Rochester, MN. "It does not work. Those data are clear and unambiguous. We have got to get past this."

Moreover, decades of voluntary programs chock full of incentives and educational outreach have reached a level of diminishing and dismal returns: Little more than one-third of health care workers bother to be vaccinated during any given flu season.

"I want to believe and you want to believe that education works," Poland said. "It does not when it comes to this topic. I am sorry, it doesn't work. I wish it were otherwise. No study has been able to demonstrate significant sustained [vaccination] increases for any sustained time period as a result of educational efforts. It is not the answer. This has failed as the only strategy we have had — trying to encourage people, provided free [vaccine and] education. It simply hasn't worked."

The health care system will "either lead or be lambasted" on the issue given trends for patient safety and empowerment, consumer demand for health care accountability and increasingly negative press coverage.

"We have to take responsibility for this parade of deaths that happens year in and year out in our hospitals," Poland said. "Personal preference, I do not believe, is defensible in any way for a health care worker. We will be called to account here. Only 36%-40% are getting immunized each year. The vast majority of us are not getting the vaccine."

Given the situation, the APIC board of directors voted earlier this year to endorse mandatory influenza vaccination for health care personnel who have direct contact with patients. "I am just overjoyed that you took one of the early leadership positions in this and endorsed mandatory flu immunization," Poland told APIC attendees.

Health care workers and their employers have an ethical and moral duty to protect vulnerable patients from transmissible diseases, Poland said. "I believe they will have a legal duty, too," he added, noting that flu vaccination for health care workers in acute care is now mandatory in seven states. Fifteen states mandate the shots for workers in long-term care, Poland said.

"There are now six lawsuits against physicians

and health care institutions that failed to deliver the vaccine, and there was the suspicion that [flu was nosocomially] transmitted," Poland said. "You leave yourself vulnerable."

While short of a mandate, the current standard of care is requiring workers who decline flu shots to sign declination statements. "This should be seen as a matter of meeting professional and ethical standards, not personal preference," he said. "Unvaccinated health care workers should be excluded from direct patient care."

The situation is particularly disconcerting in an era of patient safety, when more and more public and media attention is focused on adverse outcomes in health care.

"Your colleagues do not necessarily understand," Poland said. "The reason for them to get vaccine is to protect somebody else. That is the primary reason — first, do no harm. It is a patient safety issue and a moral and ethical imperative.

It is a win-win-win-win: the patient benefits, the employee benefits, the institution benefits, and the community benefits."

Poland cited numerous studies showing nosocomial transmission of influenza from unvaccinated workers to patients. "Influenza-infected health care workers transmit this deadly virus to their patients," he said. "A fact many of you do not know is that health care workers with asymptomatic influenza can transmit this virus to patients and to other staff. In fact, they can do so for about 24-36 hours before they develop symptoms or even if they never develop symptoms. Multiple studies show that about 70% of health care workers continue to work despite the fact that they are symptomatic for influenza."

Complications of influenza are particularly burdensome on certain subsets of patients, including children younger than 2 years old. "Until recently I was not aware of this," Poland said. "They have a mortality rate as high as 15%. That is sort of stunning."

Poland cited a flu outbreak in an NICU in which a baby died after being exposed to infected health care workers. "This one is a tough one for me," he said. "Try to get your head around this. You go to a hospital to deliver your high-risk baby in the United States in 1998 — best health care system in the world, right? And your baby dies of an infection that was preventable by a $15 vaccine. In fact, for the health care worker, it wouldn't have cost anything at all."

Other vulnerable patient groups include the elderly, the immunocompromised, and critically ill patients. Patients acquiring flu in the hospital results in increased costs, extended lengths of stay, and death.

Surprisingly, nursing is the health care work segment with the greatest entrenched resistance to being vaccinated against flu, Poland said. "[Nurses] have consistently lower vaccination rates than any other group, and the big concern is that there is no other group of health care workers who have closer and more prolonged contact with patients," he said. "There are no data that show education changes this. Furthermore, nurses have more reasons for rejecting vaccine than all other health care workers and are more likely to believe it is not safe or effective."

'Ignorance is killing people'

The reasons typically given by health care workers for refusing the vaccine include that they never get the flu, pose no risk to patients, fear of vaccine side effects, fear of needles, or belief that the vaccine causes flu. The vaccine is safe and effective and does not cause the flu, Poland emphasized, adding that he personally conducted a study that showed that a sore arm at the immunization site is the only actual side effect that has statistical significance when comparing flu vaccine to a placebo.

Beyond the health care setting, flu is somewhat underappreciated as an infectious disease threat during a typical, nonpandemic year. Yet seasonal flu kills an average of 36,000 Americans annually, almost as much as breast cancer (40,000), and three times as many as HIV/AIDS (14,000).

"If I got up here today and announced we had discovered a safe and effective vaccine against breast cancer, do you think it would take me six decades to get 36% of the women of this room to take that vaccine?" Poland said. "One out of every 10,000 Americans that are alive today will be dead by next flu season because they didn't get a flu shot."

While it is not clear how many flu deaths are directly linked to health care, all evidence shows transmission is occurring. "We know from serologic studies that about 25% of health care workers each season actually have antibodies that show that they are infected with one of the currently circulating strains," he said. "About 50% of the health care workers who have that evidence were unaware that they had influenza. One of the things that I hear a lot is that 'I never get the flu.' Yes you do, you just don't know it and that ignorance is killing people." ■

(Continued from page 118)

to be reimbursed appropriately and what procedures and conditions can change the DRG of a patient. The care managers have the clinical knowledge to discuss any documentation problems with the physician, Rongo says.

"The coders and care managers work together as a team. No matter how much training care managers have, they don't have the kind of detailed knowledge that coders have, but they are in a position to prompt physicians with questions about the patient's condition and plan of care," she adds.

In addition to increasing revenue to the hospital, the documentation enhancement program helps justify medical necessity and length of stay, assists in appealing denials, and has improved the hospital's comparative data by accurately reflecting the complexity of the patients being treated, Rongo points out.

"When documentation is not complete, it's a double-whammy. Not only does the hospital lose

CMS

(Continued from cover)

The changes could have a tremendous effect on hospital reimbursement and are likely to require much more documentation in order for a hospital to receive the reimbursement it is entitled to, says **Deborah Hale**, CCS, president of Administrative Consultant Services Inc., a health care consulting firm based in Shawnee, OK.

The proposed rules would base the payment rates assigned to DRGs on hospital costs rather than charges, by basing the calculation of the DRG-relative weights on the newly developed hospital-specific relative values cost center (HSRVcc) methodology.

In addition, CMS proposes to replace the current 526 DRGs with either a proposed 861 severity-adjusted DRGs or an alternative severity-adjusted DRG system developed in response to public comments being solicited on the issue.

The proposal calls for increasing the 526 DRGS to 1,258 all-patient refined DRGs, (APR-DRGs) developed by 3M, then ultimately refining the system by consolidating the APR-DRGs into a new DRG system with 861 consolidated severity-adjusted DRGs or CS-DRGs.

"The changes in methodology will create four DRGs per diagnosis based on severity. Under the APR-DRGs, certain diagnoses or combinations of diagnoses could put a hospital into a higher reimbursement category. The new methodology will require more documentation and it will become critical that the documentation reflect all of the services the patient receives," Hale says.

CMS is expected to issue its final rule early in August. CMS proposes implementing the hospital-specific cost weights in fiscal 2007 and to adopt the severity DRG system in 2008, if not earlier.

CMS issued a statement saying that the new methodology will improve the accuracy of the hospital payment system and lead to better incentives for hospital quality and efficiency.

"The hospital payment reforms we are proposing . . . will mean payments for hospital inpatient services will more accurately reflect the costs of providing the services. We are taking important steps to make payments fairer to hospitals and to assure beneficiary access to services in the most appropriate setting," says CMS administrator **Mark B. McClellan**, MD, PhD.

The proposed changes are based on recommendations from the Medicare Payment Advisory Commission (MedPAC) and Congressional concerns that the existing system may create incentives for some hospitals to "cherry-pick" the most profitable cases, according to a statement issued by CMS.

In a 61-page document sent to McClellan, **Rick Pollack**, executive vice president of the Chicago-based American Hospital Association (AHA), expressed concerns about the proposed changes in the DRG weights and classifications.

"We believe the AHA and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. However, more time is needed to understand the significant proposed policy changes, which redistribute from $1.4 to $1.7 billion within the inpatient system," Pollack wrote.

The AHA proposes a one-year delay in the proposed DRG changes to address concerns about the HSRVcc methodology, which the AHA says is flawed.

In addition, the organization, which represents 4,800 hospitals, called for the changes to be phased in over a three-year period.

The new rule proposes that Medicare should not pay for care of patients who develop complications that could not have been prevented.

"CMS says it is going to stop paying for at least two conditions that could have been prevented in the hospital," Hale says. The two conditions have not yet been determined, she adds. ■

revenue opportunities, but when you look at comparative data, it appears that the hospital is charging a lot more for cases that are less complex than those at other hospitals," she adds.

If the hospital's cost and mortality are high, it may be because the comorbid conditions are not documented. This may appear to be a quality of care issue when actually it is a documentation problem, Rongo notes. "The reality is that the complexity of our patients was greater than it seemed, but because of documentation, our data didn't show it before we started the documentation improvement project. If it's not in the chart, you can't code it," she says.

Under the documentation improvement system, the additional documentation that is needed is added to the charts concurrently, rather than after the patient is discharged and the chart is sent to the health information department to be reviewed by the coders.

"With the old system, there were times when we couldn't question the documentation because the chart was already complete. Now we do it concurrently and document why the patient is in the hospital and the complexity and intensity of services," says **Michele Rando**, concurrent documentation enhancement coordinator.

Utilization review

Physicians respond better when the care managers raise the questions concurrently, rather than when the coders raised the questions after the patient was already discharged, Rongo adds.

"When a new patient comes onto the unit, the care manager attaches a "Problem List," a one-page sheet, to the patient's chart and uses it to make notes on areas of concern.

When the care managers conduct utilization review, they make a note of any problems or questions that need to be addressed during the patient stay or anything that is in the patient's history. The coder reviews the list, looks at the medical records, and identifies the kind of questions the care manager should be asking the physician and notes them on the problem list.

For instance, a patient is admitted with pneumonia and the chart shows that there is a positive sputum culture for *Staphylococcus aureus* and that the physician changed the antibiotic treatment, following the positive culture. Rando writes a query on the chart for the care manager to check with the physician to see if the pneumonia was caused by the organism and to enter it on the chart. As a result, the diagnosis changes the DRG to one that receives a higher reimbursement.

Rando reviews between 60 and 90 charts a day, depending on how many patients are on the units she covers. The system allows her to track and report how much revenue was generated by the enhanced documentation.

"We compile a list of documentation that is added based on the concurrent review and to track the dollar amount that the correct documentation generated," Rongo says.

The team approach works well, she points out.

The care managers are clinicians who understand the medical aspects of the patient's condition.

The coders have expertise in coding with knowledge of the codes and coding guidelines. They have a two-year associate's degree in health information management, then sit for an examination to become certified as a registered health information technologists (RHIT) and complete 20 hours of continuing education for a two-year period.

"The coders have an entirely different body of knowledge from the care managers. Coding and documentation is a specialized area, and I didn't feel it was appropriate for the case managers to invest that much energy into a complicated process, which might divert them from their core duties. The coders help us discern what documentation will make the coding more accurate and result in higher reimbursement," she says.

The hospital started its documentation improvement program in 2001 by bringing in a consultant to educate the physicians on how to document more accurately. "We had looked at our risk assessment and felt that we weren't capturing all the comorbid conditions. We wanted to improve documentation in order to increase reimbursement, assure documentation of medical necessity, and improve how we compare with other organizations from a data perspective," she says.

Rongo calls the work with the consultant "moderately successful." "It created some additional awareness. We focused on taking education to the care management level and having the care managers work with the physicians as quasi coders," she says.

The coders and the case managers met to determine opportunities for improvement in documentation and designed a pilot project for one unit.

During the project, a coder came onto the unit and worked with the care managers to identify comorbid conditions and other symptoms that could affect the coding.

During the three-week pilot on the orthopedic

unit, the case management-coding team was able to show that its efforts increased revenue by $33,000 just by documenting and coding accurately the complexity and intensity of services provided. For instance, if a patient received a blood transfusion, the coder asked the care manager to inquire of the physician the reason the patient got the blood.

Adding anemia or postoperative blood loss as a complication of surgery results in a bigger reimbursement. "In total, those subtle changes in documentation can dramatically increase revenue," Rongo says.

Following the success of the pilot project, the hospital gradually expanded the initiatives to more units.

In 2003, the documentation enhancement resulted in $650,000 in additional revenue. By 2005, the total was more than $1 million in increased revenue generated just by the documentation enhancement project.

The documentation enhancement program has been well received by the hospital's attending physicians, Rongo says. "Physicians are increasingly concerned about how they look when it comes to comparative data. The care managers are able to tap into this and educate the physician that if they don't document clearly that they are treating a complex patient, it will appear that he or she is treating less complex patients compared to the peer group."

The quality management department gives physicians risk-adjusted comparative reports, allowing them to see the effects of documentation both internally and externally. "The care managers tell the physicians that improved documentation will give them credit for the type of patients they are treating. The physicians also understand that the better the clinical documentation, the better chance we have to successfully appeal denials," she says.

The hospital's nurse care managers report that many of the physicians find the problem list on the chart to be helpful, especially when they are covering for another physician and because it provides them with a view at a glance of everything that is going on with the patient. Some physicians use the problem list when writing their discharge summaries.

The hospital is conducting a pilot program using a new problem list that includes information on the DRGs covered under the post-acute transfer rule from the Centers for Medicare & Medicaid Services that went into effect last October.

CE *questions*

5. CMS has proposed increasing the number of DRGs from 526 to how many severity-adjusted DRGs?
   A. 752
   B. 861
   C. 630
   D. 953

6. When patients at Mercy Regional Medical Center in Durango, CO, they have to go to the next biggest city, Albuquerque, NM. How far away is it?
   A. 50 miles
   B. 87 miles
   C. 200 miles
   D. 250 miles

7. Case managers and coders work as a team on a documentation improvement program at United Health Service Hospital in Johnson City, NY. How much in increased revenue did the program generate in 2005?
   A. $1 million
   B. $500,000
   C. $350,000
   D. $2 million

8. A prenatal case management program at Crozer-Keystone Health System reduced the infant mortality rate among African American infants in and around Chester, PA, from 21 deaths per thousand to ____.
   A. 15 deaths per thousand
   B. 14 deaths per thousand
   C. 12 deaths per thousand
   D. 18 deaths per thousand

Answer key: 5. B; 6. C; 7. A; 8. B.

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a certificate of completion. ■

The new list includes the working DRG and the geometric mean length of stay for that DRG.

"We want our care managers to have an awareness of which DRG is likely to be a transfer DRG and the geometric mean length of stay for that DRG to help them in managing the care of the patients and moving them through the continuum safely and efficiently," Rongo says. ■

Initiative focuses on at-risk pregnant women, moms

Infant mortality rate drops, vaccinations increase

An initiative to improve the health of pregnant women and their infants and toddlers has resulted in a drop in the infant mortality rate for Crozer-Keystone Health System**.**

When the Crozer-Keystone Healthy Start was begun in 1997, infant mortality and morbidity for African-American infants was 21 infant deaths per thousand in and around Chester, PA. The number has dropped to 14 infant deaths per thousand. The national average is about 6.5 infant deaths per thousand. The Chester area's rate is 10.8 infant deaths per thousand.

As a result of the interventions by community-based case managers, 100% of participants have a medical home, and the immunization rate is greater than 90% for the children in the program.

Crozer-Keystone's Healthy Start program was begun when the hospital received a grant from the federal Bureau of Maternal and Child Health as part of a national initiative to reduce infant mortality and morbidity. The project serves 11 municipalities in and around Chester.

The program provides a variety of free services to pregnant women of any age and families with children younger than 24 months who live in the project service area. The program serves publicly and commercially insured women, women who have no insurance, and those who are undocumented immigrants. There are no income requirements.

"We actively seek out participants through outreach and recruitment. Our staff is out in the street and in the neighborhoods, letting people know about our services. We go anywhere we can to find women and families who are eligible for the program. If we find pregnant girls and women early in the pregnancy, we can have a bigger effect on the outcomes,"says **Joanne D. Craig**, MS, project director.

More than half of the participants in the program refer themselves after hearing about the program from other participants.

Women who are referred to the program are assessed by a hospital social worker who conducts an extensive assessment at the hospital or her home or place of business. The intake assessment includes a physical and psychosocial assessment, a depression screening, and an education survey. Families are assigned a risk level from 1 to 4. About 85% are level 3 or 4.

Program participants who qualify as high risk are those who are not in school or unemployed, those with an unstable housing situation, patients with chronic mental health or medical problems, who are substance abusers or victims of domestic violence.

"We have a growing population of pregnant girls who are 15 or younger. This automatically qualifies them as a Level 4 risk," says **Donovan Pratt**, MSW, LSW, case management coordinator.

Community-based care

The case managers who work with the pregnant women are community based and often live in the neighborhoods they serve. As soon as they are assigned a family, they meet with all of the agencies involved with the family and review each agency's role in order to increase efficiency and eliminate duplication of services.

"We work with child protective services, the court system, school systems, mental health providers, and other agencies. We all work together to ensure that the child and the parent will be healthy," Pratt says.

The case managers meet with the families in the community and work to develop a family plan of care that is regularly reviewed and updated and may be completely revised every six months.

They make regular visits and phone calls to the families, depending on the risk level and the needs of the family.

The case managers educate the program participants on factors that could affect the outcome of the pregnancy, such as dietary considerations and stopping smoking. They help the pregnant women get ongoing prenatal care, often picking them up and taking them to and from their doctor visits.

"We take them to the welfare office, take them to the market, and shop with them to pick up the healthiest foods," Pratt says.

If the program participants are homeless, the case managers help them find stable housing. They help arrange treatment for mental illness, substance abuse, or other problems.

If the patient is a pregnant teenager who still is in school, the case managers make sure she keeps going to class. If the woman is a victim of domestic violence, the case manager helps her get to a safe place.

"We're doing more than just working with women related to pregnancy. We look at all the other issues that may have a negative effect on the birth outcome and help the women meet any concern or need they may have. The population we are working with is very vulnerable. Often the pregnancy is the least of what we need to address," Craig says.

The case managers check on the members regularly, by phone or in person, depending on the risk level of the family. Once the baby is delivered, the case manager follows the family until the child is 24 months old.

"We like to see the child through the series of childhood immunizations and well-child visits. In addition, we want the women to have the necessary postpartum visits to the doctor and to take an adequate amount of time to help before they have more children," Craig says.

The case managers provide transportation for the well-child and specialist visits.

"Some of the children go to a specialist 15 or 20 miles away at a children's hospital. It could be an all-day visit," Pratt says.

If a woman gets into the program early on in the pregnancy, she could be in the program for two years. Participation can be longer if she becomes pregnant again by the time her child reaches the cutoff age of 2 years.

When program participants are discharged, the case managers make sure they are connected to community services.

The case managers participate in care conferences with the project's care coordination team. They meet with Craig weekly and review five or six cases to go over problem cases and to get suggestions on managing the care of the family.

The program's case managers meet twice a month at a case management meeting to go over whatever issues they may have and to try to find ways to remedy problems.

"We utilize the experiences of the case managers to see how we can improve on the services we are already providing," she says.

Caseloads

A case manager's typical caseload was 20 to 25 but has recently been decreased to 17 to 20 because of the high acuity of the patients and the intensity of their needs. "Our population tends to be needy, with problems that are compounded and convoluted. The pregnancy is probably the easy part of the equation," Craig says.

The most challenging patients are young teenage girls who have serious mental health issues, such as bipolar disorder and schizoaffective disorder.

"These young women are going through the issues of self-esteem and self-confidence that affect every teenage girl. These girls are pregnant, have a mental disorder, and are in school. They worry about things that other 14-year-olds don't have to face," Craig says.

The case managers help the young women understand their illness, how it can exacerbate throughout the pregnancy, and why it is important that they get treatment.

CE objectives

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

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■

COMING IN FUTURE MONTHS

- Why case managers must be involved in medication reconciliation initiatives
- How a documentation enhancement program can increase revenue
- Everything you need to know about the new Medicare rules from CMS
- Managing recruitment and retention in a competitive market

"Many of the mental health disorders are hereditary, and some of the young women are reluctant to acknowledge that they have the same problems that someone in their family has. The case managers work closely with mental health services to monitor the patients," Pratt says.

A bilingual and bicultural case manager with knowledge of immigration law and community resources manages the undocumented immigrant populations, most of whom are from South America and Central America.

"This is a population where we clearly see a high rate of self-referral. She takes great pains to build a relationship and trust with these women. Many of them decline to move out of the area so they can remain close to her," Craig says. ■

JCAHO creates flu immunization standard

The Joint Commission on Accreditation of Healthcare Organizations has approved a new infection control standard that requires accredited organizations to offer influenza vaccinations to staff, which includes volunteers, and licensed independent practitioners with close patient contact. The standard will become an accreditation requirement beginning Jan. 1, 2007, for both hospitals and long-term care facilities.

The Joint Commission developed the standard in response to recommendations by the Centers for Disease Control and Prevention making the reduction of influenza transmission from health care professionals to patients a top priority in the United States. The new standard requires organizations to:

- establish an annual influenza vaccination program that includes at least staff and licensed independent practitioners;
- provide access to influenza vaccinations on-site;
- educate staff and licensed independent practitioners about flu vaccination; nonvaccine control measures (such as the use of appropriate precautions); and diagnosis, transmission and potential impact of influenza;
- annually evaluate vaccination rates and reasons for nonparticipation in the organization's immunization program;
- implement enhancements to the program to increase participation. ■