HOSPITAL CASE MANAGEMENT™

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

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IN THIS ISSUE

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Brace yourself for changes in the DRG model with more on the way

Reimbursement will be tied more closely to severity

The Centers for Medicare & Medicaid Services (CMS) has announced significant changes in the inpatient prospective payment system, including interim steps toward a comprehensive revision of the DRG model to tie reimbursement more closely to the severity of the patient's condition.

The final rule, which takes effect Oct. 1, includes the creation of 20 new DRGs in 13 clinical areas and modifications to 32 existing DRGs to better capture the difference in severity. The DRG changes for 2007 are just an interim step toward more comprehensive changes under development for fiscal 2008, with the goal of better accounting for severity across the entire DRG system.

At the same time, CMS took the first steps toward cutting reimbursement for hospital-acquired infections by creating two new DRGs for infectious or parasitic diseases resulting in an operating room procedure, proving $10,000 less in reimbursement for postoperative or post-traumatic infections.

The 2007 fiscal year also begins a three-year transition to using hospital costs instead of hospital charges as a basis for reimbursement. For fiscal 2007, one-third of hospital payments will be determined using estimated hospital costs.

The final rule takes significant steps to improve the accuracy of Medicare's payment for inpatient stays, CMS says. In issuing its final rules for the inpatient prospective system for August, CMS identified the following goals for the changes:

- making meaningful first steps in diagnosis-related group (DRG) reform in 2007, with plans to continue reforms in 2008;
- taking steps toward more accurate payments without disrupting hospital payments;
- ensuring that Medicare does not overpay for some services while

underpaying for more severely ill patients and those with complex illnesses;

• correcting inappropriate hospital incentives for treating certain types of patients and providing certain types of services by redirecting a portion of the payments from cases that are currently overpaid to those that are underpaid.

At the same time it issued the final rule, CMS announced its intention to hire a contractor to evaluate proposals for an alternative DRG system and to release an interim report for public contact by the end of the year. The alternative DRG system is slated to go into effect in fiscal 2008.

The changes for fiscal 2007 include DRG refinements for sepsis patients on mechanical ventilation, a new DRG for carotid stents, and changes in the DRGs for major GI diagnoses.

Some DRGs have significant payment increases, and payment for some is reduced. However, CMS says no DRG's payment has been reduced by more than 5.4%.

"The point that CMS is making is that the current DRG system does not accurately capture the severity of illness. In some cases, it has created overpayment and, for some diagnoses, hospitals are being underpaid. The severity-refined DRGs will more accurately base payments on the actual severity of the patient's condition," says **Deborah Hale**, CCS, president of Administrative Consultant Services Inc., a health care consulting firm based in Shawnee, OK.

The changes CMS made in the final rule will give hospitals better reimbursement by accounting for severity and more accurate data, which they can use to identify areas where changes may be needed, Hale adds.

"The severity-adjusted DRGs are a victory for hospitals. They may have to work harder on documentation improvement, but the new DRGs will tie the hospital's reimbursement more closely to the patient's condition," Hale says.

The changes mean that it is more important than ever to have physician documentation that provides the most specific information available about the coding staff and that the coding staff use this documentation to assign the case to the right DRG, Hale says.

The DRG modifications provide more opportunities for case managers to focus on specific areas of clinical documentation to make sure that what is in the patient's chart more accurately reflects the patient's condition, Hale says.

"For case managers, the changes provide a DRG system that better reflects the severity of illness, instead of grouping patients with a particular diagnosis into a broad category," she says.

Case management departments that look at profit and loss by diagnostic category will have much better data to use to identify areas for improvement, she adds.

One of the most significant changes is the elimination of DRG 416 (sepsis), which has been replaced by two new DRGs that provide higher reimbursement for patients with sepsis who are on mechanical ventilation for an extended period,

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Hale says.

DRG 575 covers septicemia with mechanical ventilation for 96 hours or longer. DRG 576 is for patients with septicemia without mechanical ventilation, or who have been on mechanical ventilation for less than 96 hours.

"Sepsis is in the top 10 DRGs for many hospitals, so this could have a big impact on reimbursement. The challenge for case managers is to make sure that the physicians use the specific language to indicate sepsis rather than terms like urosepsis or bacteremia," Hale says.

The new DRGs also significantly increase reimbursements for patients who have been on mechanical ventilation long periods of time by replacing DRG 475 with DRG 565 for patients with a respiratory diagnosis on a ventilator for 96 hours or longer and DRG 566 for patients with a respiratory diagnosis on a ventilator for less than 96 hours.

Under the new DRG system, carotid artery stent procedures should be reported under new DRG 577.

The changes were made because CMS recognized that charges for these procedures were 26% higher than those of other cases currently assigned to DRG 533, Hale says.

Other significant changes are for diagnosis in the digestive system and include the creation of the "Major GI Diagnosis" category. The changes, which are similar to the major cardiovascular disorders implemented in fiscal 2006, can have a substantial impact on reimbursement for GI procedures, Hale says.

The new DRGs recognize higher severity for some gastrointestinal diagnoses, she adds.

For instance, reimbursement can differ by $8,000 for patients with a major bowel procedure, depending on whether a major gastrointestinal diagnosis is present either as the principal or secondary diagnosis, Hale says.

Two new DRGs have been added for infectious or parasitic diseases resulting in an operating room procedure. DRG 579, infectious diseases where the principal diagnosis is postoperative or post-traumatic infection, will result in approximately $10,000 less in reimbursement than DRG 578 (infectious or parasitic diseases), Hale says.

The new DRG follows CMS' announcement that Medicare should not pay more for the care of patients who become infected as a result of their patient care than it pays for a patient who does not have a complication.

"CMS ultimately plans to stop paying for conditions that could have been prevented in the hospital, such as if a patient comes in with a heart attack and develops pneumonia," Hale says.

The final rule removes major bladder procedures from other DRGs and provides separate reporting and increased reimbursement, she adds.

The switch to basing reimbursement on costs rather than charges will not affect case managers, Hale says.

Impact on hospital payments

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.

The final rule particularly targets specialty hospitals that pick patients with the highest reimbursement, leaving community hospitals with the patients whose care may exceed the reimbursement, Hale says.

"The changes will better align payment with the cost of care by increasing payments for some services and decreasing payments for others in a way that adds up to only limited impact at the hospital level but significantly more accurate payment for each patient treated by the hospital," CMS said in a statement.

There will be limited impact on hospital payments because of the incremental reforms for the cost-based and severity-adjusted payments, according to a statement issued by CMS, which estimates that only 2% of hospitals will have a projected reduction in payment.

Payments to all hospitals will increase by an average of 3.5% for fiscal year 2007.

CMS estimates that more than 1,000 hospitals in rural areas will see an average increase of 3.7% in 2007 due to the changes and urban hospitals can expect an average increase of 3.4%. Cardiac specialty hospitals will receive an average increase of 1.2% because of payment refinements.

No DRG weight will decrease by more than 5.4% in 2007, and 19 DRG weights will increase by more than 5%, according to a statement issued by CMS.

This year's changes are the beginning of the most significant revision of Medicare's inpatient hospital rates since 1983.

In its proposed rule for 2007, released in April, CMS had announced its intentions to replace the

current 526 DRGs with either 861 severity-adjusted DRGs or an alternative severity-adjusted DRG system. In 2007, CMS will be using a total of 538 DRGs. CMS has contracted with a research firm to evaluate alternative DRG severity systems and expects to implement a new system by fiscal 2008.

"MedPac [The Medicare Payment Advisory Commission] has been pushing hard to implement a severity-refined system, but the bottom line is that CMS realized it was not ready to implement such comprehensive changes," Hale says.

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Initiative focuses on eliminating roadblocks

Goal is top 10% in core measures

At Edward Hospital in Naperville, IL, advanced practice nurses take the lead in meeting the hospital's goals of being in the top 10% of the core measures and other performance measures.

The board of directors and senior staff of the health system made a commitment in 2005 to be in the top 10% and appointed a work group to develop ways to improve compliance with the core measures. The group included the administrative staff, coders who handle utilization review, and representatives from the medical records department.

The core measures are part of the clinical scorecard that is reported to senior leadership, the board quality committee, and people in the clinical area.

In the most recent data, the hospital scored in the 90th percentile for 13 out of 23 measures.

The advanced practice nurses worked with the utilization review staff and medical records to analyze the medical records data, looking at ways to improve compliance with the core measures.

The task force met once a week for months to look for reasons that the quality measures were not being followed and to come up with ways to ensure that the core measures would be met.

"It was like peeling back the layers of an onion, trying to figure out all the potential ways to create processes that will make us 100% successful," says **Patti Ludwig-Beymer**, RN, PhD, administrative director for education and research at the 300-bed regional health care provider.

The heart hospital had been a longtime participant in the American Heart Association's "Get with the Guidelines" initiative and had been tracking data for the myocardial infarction (MI) and heart failure core measures for a long time, says **Lynn Cochran**, RN, MS, director of cardiovascular inpatient services.

The hospital had standard protocols in place for acute MI, pneumonia, and heart failure.

"Compliance wasn't as good as we wanted. We talked with the physician practice committee to recommend that the protocols be utilized," Cochran adds.

One of the team's first initiatives was to identify where patients whose care falls under the core measures guidelines were likely to be admitted and what staff would be responsible for their care.

"We determined that pneumonia was the most challenging diagnosis to identify. When we examined the records, we found that 80% to 85% of pneumonia patients were in one of two units," says **Lynn Wagner**, RN, MS, CNAA, administrative director for critical care and the medical-surgical units.

The team found that the patients most likely not to receive the recommended care for pneumonia contained in the core measures were those who were admitted directly to the hospital, rather than those who came through the emergency department.

"We engaged the nursing supervisors on the two units where the vast majority of pneumonia patients were admitted and educated them about the four-hour window for antibiotics," Wagner says.

Access to the medications was one of the time delays in meeting the measure that calls for pneumonia patients to receive antibiotics within four hours of admission.

"We analyzed the data to find where the time delays were. Among the gaps were that nursing was having a hard time getting the physician to order the medication, the order wasn't being received by the unit clerk, or the nurse was busy and didn't give the medications," Wagner says.

The pharmacy department made sure that all of the standard antibiotics for simple and complex pneumonia were in the hospital's medication dispensing system on all nursing units.

"We identified the gaps and eliminated as many as we could. We knew that if the medication was

readily available in the medication dispensing system that it would cut down on the time," Wagner says.

At the same time, the team worked to make the staff aware of the four-hour window for antibiotics to be administered to pneumonia patients.

"We found that this recommendation had not been common knowledge among the staff," Wagner says.

Another challenge was making sure patients with multiple comorbidities or ambiguous diagnoses received the treatments recommended under the quality initiatives.

"When someone comes in with an acute MI or heart failure, we know about it and we are aware of the diagnosis for the majority of people who are admitted with pneumonia. However, there are some patients who come in with confusing diagnoses and we don't know the final diagnosis until after discharge," Cochran says.

For instance, a patient may be admitted with a fractured hip and then the physician determines after evaluation that the patient had a heart attack as well. The patient should receive the measures recommended in the core measures for acute MI.

The advanced practice nurses and the coders worked together as a group to determine how the ambiguous cases should be coded.

"Our team had a lot of 'aha' moments while we were working. Until we started to analyze what was going on, we didn't understand all the problems," Cochran says.

For instance, smoking cessation education is a requirement for patients admitted with MI, heart failure, and pneumonia.

They found that six different people in different areas of the hospital were involved in documenting smoking cessation, ranging from the cardiovascular educator to the respiratory therapist.

"We got together to determine who was responsible for what and if we could agree on a similar template for documentation," she says.

For instance, some of the staff who were responsible for smoking cessation counseling don't work on weekends or holidays.

"We had to create a fail-safe mechanism for making sure that the education took place," Cochran adds.

The team involved the clinical and education staff, who agreed on standardization.

Now, if the patient has not received the smoking cessation education, the nurse is prompted to print out the materials and give them to the patient.

Cochran attributes part of the success of the initiative to educating the staff nurses. The hospital held facilitywide training for the nursing staff in the spring to help them understand what the core measures are and why they are being reported.

"We talked about the reasons for the core measures and how the evidence-based medicine behind this practice promotes better patient outcomes. Now that they understand what we are aiming for, the nursing staff wants to participate in helping us meet the core measures," Cochran says.

The initiative has helped in other ways, such as improving documentation in the patient chart. The hospital does not conduct concurrent review but reviews the data retrospectively. In the past, the team on the unit was not aware of problems in documentation.

Because of the collaboration, the chart abstractors alert the advanced practice nurses when a chart doesn't have enough information so the rest of the medical staff can be educated to include the information in the future.

For more information, contact: Patti Ludwig-Beymer, RN, PhD, at e-mail: pludwig-beymer@edward.org. ■

APNs ensure patients move through the continuum

Nurses lead the care management team

Case management is a collaborative process at Edward Hospital in Naperville, IL, with advanced practice nurses leading a team that includes utilization managers, social workers, and staff nurses.

Having the advanced practice nurse lead the care management team helps ensure that patients receive optimal care in a timely fashion and move quickly through the continuum, says **Patti Ludwig-Beymer**, RN, PhD, administrative director for education and research at the 300-bed regional health care provider.

"From my perspective, after being in nursing for 33 years, advanced practice nurses can move the patients along faster because they have prescribing authority and can write orders, clearing the way for patients to be discharged in a timely manner," she says.

The hospital, which achieved the prestigious Magnet Award for nursing, has been using the practice model for more than 10 years.

"Advanced practice nurses are extremely knowledgeable about patient needs and patient care. Over the past year, as we have focused on the core measures data, the case management piece of the advance practice nurses role has increased. We believe that our hospital is forward-thinking and has the best-educated people possible providing patient care," she adds.

The advanced practice nurses have a collaborative practice agreement with physician groups that allows them to write orders and discharge patients from the hospital under the guidelines of the practice group under which they work. They collaborate with the treatment team on patient care and work with the utilization staff to monitor length of stay and documentation.

"The model is rich in dollars, but it's also rich in knowledge. The advanced practice nurses bring a lot of talent to the table, and they can move the patients quickly through the health system. They are well trusted by the physicians, who treat them just like a colleague," says **Lynn Wagner**, RN, MS, CNAA, administrative director for critical care and the medical-surgical units.

The advanced practice nurses are the frontline care providers for patients in the hospital. If the bedside nurse has a question or sees that a patient has a problem, she calls the advanced practice nurse on her team, who may order medications or tests or call in the cardiologist if necessary, adds **Lynn Cochran**, RN, MS, director of cardiovascular inpatient services.

"As a piece of their role, they serve as physician extenders. They can clinically manage the patients, write orders, and work with their physician partners," Cochran says.

All members of the care management team are in constant contact all day about the patients and the discharge plan, she adds.

"The utilization review staff are in frequent contact with the advanced practice nurse and the physicians to ensure that the patient is moving through the continuum smoothly," Cochran says.

Because they are in the charts and at the patient bedside all day long, the advanced practice nurses know from daily practice what the barriers are to getting patients through the system, Ludwig-Beymer says.

They serve on the team that examines ways to streamline the patient throughput process by ensuring that tests results are back in a timely manner and that patients with the potential to be discharged get a high priority on the list, Ludwig-Beymer adds.

Eliminating delays

The multidisciplinary team meets weekly to discuss patients who have been in the hospital for seven days and look for obstacles that need to be overcome for the patient to be discharged.

When a patient is ready to be discharged, the advanced practice nurses are on the floor and can write the discharge orders, eliminating delays in discharge, she adds.

The advanced practice nurses have worked with the rest of the hospital staff to standardize treatment regimes so that every patient is treated under evidence-based guidelines, Ludwig-Beymer says.

One advanced practice nurse works with the emergency department to educate the ED staff on patient protocols and to make sure that standing orders for cardiac and pulmonary patients are followed.

The advanced practice nurses are credentialed by Edward Hospital's internal medicine credentialing body.

The seven advanced practice nurses at Edward Heart Hospital have collaborative practice agreements with the physician groups that practice at the hospital.

"We have one big cardiology group that often has as many as 70 patients in the hospital. The advanced practice nurse can't see all of them, but between them, the doctors and the nurses see all of the patients every day," Cochran says.

The six advanced practice nurses who work on the med-surg floors have collaborative agreements with the highest-volume medical groups that practice at the hospital.

The nurses are assigned by unit for interdisciplinary rounds on some of the med-surg floors. They always are available to any staff member who has questions or concerns about a patient.

The advanced practice nurses are primarily employees of the hospital, with most of their salary paid by the institution. The heart hospital invoices the physician practice group for a percentage of the nurses' salaries.

In addition to managing patients in the clinical setting, the advanced practice nurses track patients who have implanted devices, are members of the hospital's rapid response team, and are involved in clinical research. ■

CRITICAL PATH NETWORK™

Team approach to improving documentation pays off

CMs, documentation specialist work together closely

A team approach to documentation enhancement has resulted in a reduction in accounts receivable days, more accurate billing, and dramatic decreases in the number of queries to physicians for clarification about documentation at the Catholic Health System of Buffalo, NY.

The documentation enhancement initiative is a joint effort involving the medical staff, care management, medical records, billing and coding, and mentored by documentation specialists, registered nurses with a background in case management.

Lower accounts receivable days mean that claims are being processed without challenge or barrier.

The hospital system developed an initiative it called Teaming for Documentation Integrity (TDI) and created a work group to develop a process to ensure that documentation and subsequently coding and billing were accurate.

"We knew that whether we were looking at the system as a whole or each separate entity, correct documentation was critical for acute and post-acute coding and billing," says **Dee Cooper**, RN, BSN, CCM, CCUM, director of care management for the four-hospital system.

"The TDI effort began with a review of Medicare-benefited patients and has progressed to a review of managed Medicare-benefited patients. However, the improvement of clarity of documentation has been realized throughout the system, regardless of payer," Cooper added.

When a patient is admitted, the RN case manager performs an assessment and opens the patient chart. The case manager is the captain of the care coordination team in collaboration with the social worker who handles discharge planning and the RN discharge coordinator, who handles discharge planning and post-acute needs.

The case manager's primary functions are to validate inpatient admission status, closely monitoring the services and the time of processes to meet the hospital system's goal of having a definite diagnosis and plan for discharge in place within 23 hours of admission.

The case manager reviews the patient presentation, the physician's initial progress notes, inpatient vs. observation status, and follows InterQual criteria to determine the intensity of services the patient is likely to need.

The documentation specialist follows up to review the medical record for the primary diagnosis, then goes over the initial documentation to ensure that it is clear and supports the diagnosis.

For instance, the chart may indicate that a patient is receiving infusion and has abnormal lab values and hypothermia. If the patient had a blood culture performed, the documentation specialist concludes that the physician may be considering sepsis as the source of illness.

The documentation specialist follows the record to see the results of the blood culture and makes sure that sepsis is noted on the chart if appropriate. She mentors the physician to assure validation of the diagnosis or to ensure that the physician changes the admitting diagnosis based on the laboratory results.

"If the documentation is not clear and the lab work doesn't support the coding, the documentation specialist queries the physician asking for the diagnosis to be clarified," Cooper says.

Depending on the length of stay, the documentation specialists may review the charts two or

three times, monitoring the documentation to make sure that it meets criteria and includes all the documentation needed for coding and billing.

The documentation specialists write their queries on brightly colored paper inserted into the physician progress notes to alert the physician that there is a question.

The physician may write a note on the query sheet in addition to clarifying the documentation in the patient record.

The colored sheet is a communication tool and does not remain with the record once the documentation query has been addressed.

The care management staff in the health system operates under a geographic model. Each unit has at least one RN case manager, one discharge coordinator who is an RN, and one social worker. The documentation specialists typically cover more than one unit.

The largest hospital in the system has 302 beds and sees 40,000 patients a year in the emergency department. There are three full-time documentation specialists at that hospital, assigned by unit.

"They cover the same units all the time. This helps them in building a relationship with the physicians," Cooper says.

The case managers oversee the rest of the team to make sure the patients are moving as they should through the continuum.

"We try to break down the walls between the different roles. The team meets every morning and discusses the patient progress with the charge nurse and the medical staff as appropriate. Depending on what each patient's needs are, the social worker may take the lead, or it may be the discharge coordinator who is putting together the home care or rehab referral to CHS providers," Cooper says.

The hospital system began its documentation enhancement initiative in 2002. The first step was to create a workgroup with representatives from the medical staff, care management, medical records, billing, and coding.

The team reviewed the patient care processes at the hospital and looked at ways to make sure that documentation was correct in every patient chart. They identified trends in gaps in documentation, such as how physicians were looking at the patient's diagnosis versus how the coders were able to code it using the documentation in the chart.

"We as an organization needed to look at what information was out there and work with our physicians to develop a criteria or a documentation expectation that clearly validates that diagnosis," she says.

The first phase of the documentation enhancement project took six months.

The team developed tools for the documentation specialists to use when they were querying physicians. The tools include information that the coders use in identifying certain diagnoses, which helps the documentation specialists ask the right questions.

"They are responsible for everything from admission status to clearly identifying the primary diagnosis. The documentation specialists had to learn not to direct a physician into a specific DRG but to query as to what the physician means by what he writes on the chart," she says.

The hospital brought in external sources to provide training on medical criteria and coding.

"Whether they're looking at the chart or billing the insurer, everyone needs to understand the criteria set," she says.

The team took six months to lay the groundwork for the new process. Much of the time was spent educating the physicians about both the processes and philosophy of the model.

"We knew that if we pulled together, with all parties involved in understanding the implications of the new procedure that we would be successful," she says.

The team educated the medical staff on how to understand how the process would flow. They covered who the documentation specialists are, their backgrounds, their roles, and how they interact with the coders and the medical billing staff.

"The six months was well worth the effort. We needed to educate the physicians on the purpose of the initiative and to get their feedback in terms of what kind of queries they preferred," Cooper says.

The team continues to educate the incoming physicians at the health system's two teaching hospitals. Interns and residents go through an inservice training program right from the beginning to make sure they understand not just the process but also the purpose behind it. The documentation specialists periodically prepare "storyboards" which are placed in physician lounges and other places throughout the hospital to further educate and mentor the physicians.

The physician leadership, infectious disease doctors, nursing leadership, medical records leadership, financial management, and case management leadership at the four hospitals meet at least quarterly to review how the documentation enhancement process is working.

"The goals of the Teaming for Documentation Integrity initiative directly support the system's

quality and compliance efforts through accurate coding of the DRGs, supported by clear documentation in the medical records," Cooper says.

The hospital system began its fourth year with the process in July. When the system implements the paperless medical record system, which is in the works, the care management documents will contain an electronic alert for physician queries.

The health system, which serves Buffalo and its surrounding counties, was formed in 1999 from a group of hospitals that were operating independently.

"It was a cultural change for a long-standing organization. We had two case management models — acute case management and community case management — and two directors," Cooper says.

As part of the redesign, the case managers started using wireless laptop computers with a software program to support acute care, discharge planning, and post-acute needs.

For more information, contact Dee Cooper, RN, BSN, CCM, CCUM, at e-mail: dcooper@chsbuffalo.org. ■

Geriatric CMs collaborate on discharge planning

Hospital-based nurses keep seniors home

When an elderly patient is hospitalized at Lee Memorial Hospital in Fort Myers, FL, the case managers on the unit may call in a geriatric care manager who already has been working with the patient and has additional information that will be useful in creating the discharge plan.

While many geriatric care managers are independent contractors, Lee Memorial has a hospital-based program, Senior Care Choices.

"As a part of the health system, we can help with the continuum of care and can coordinate care for the patient between the hospital and the home, and back again when necessary. As health professionals who visit the patients in the home, we can let the nurses and doctors know what the home environment is like and what the patients are like when they aren't in the hospital," says **Dawn Moore**, RN, one of three geriatric care managers at Senior Care Choices.

Senior Care Choices receives referrals from nurses, physicians, hospital social workers and case managers, family members, trust officers, attorneys, guardians, and senior organizations.

Like other geriatric care managers, Moore is paid by the patient or the family.

Senior Care Choices is a fee-for-service program. The fact that the care managers are hospital-based makes it possible for them to establish a close working relationship with the hospital staff that pays off when a client is hospitalized, Moore adds.

When a client is hospitalized, Moore often is part of the discharge planning team. She meets with the case managers, social workers, and discharge planners, and other members of the health care team at the hospital and gives them an accurate picture of the patient's home situation and other input that helps the discharge planning team save time and make sure that the patient can be discharged safely.

"We know all the little things that can make a huge difference in the discharge plan, like the home environment and the family dynamics. We let the hospital staff know who this is beyond being a sick person. We advocate for our clients and let them know what the person is capable of doing," she says.

Because hospital stays are so short and the post-discharge needs of the elderly often are so intense, it's difficult for the hospital social workers and discharge planners to get a handle on what the patient is going to need, Moore points out.

The geriatric care managers provide someone who is aware of the elderly patients' situations and who can work with the discharge planning staff to find the best discharge destination.

"When older people are in and out of the hospital and are trying to live alone, it's easy for the hospital staff to misinterpret how well someone is doing. Repeated hospitalizations may indicate to the social worker that they can't handle living on their own. We try to keep that from happening," Moore says.

For instance, some elderly patients who are hospitalized often appear to be helpless and confused although they were living independently with support in place and doing well at home.

"We really like to participate in helping make decisions about what happens after the patient is discharged from the hospital," Moore says.

When Moore is hired by a family to manage the care of a senior, she goes into the home and performs a detailed assessment, looking at medical issues, social issues, and what support systems the client has in place. She screens for depression and memory issues and makes sure that advanced directives such as power of attorney or health care

surrogates are in place.

"We look at where their needs are, then sit down with the family or the client and family and review the needs, then come up with a plan to meet those needs," she adds.

For instance, an elderly client may need transportation to get to the doctor and the grocery store and need help with housekeeping chores. Or they may not be compliant with their medications and have difficulty paying bills.

"There's never a cookie-cutter solution. Everybody's plan of care is different depending on their needs, their personalities, and what they can afford," Moore explains.

Her goal is to do whatever is possible to keep the senior as independent as possible and to take care of any problems that arise before they become big problems. "Geriatric care management is often initiated when the senior citizen has a crisis. Our job is to prevent crises from happening and to keep our clients out of the hospital. It may be something as simple as helping the seniors find ways to be compliant with their medications or get their nutritional needs met," Moore says.

Many seniors living in the southwest Florida area are from other parts of the country and retired to southwest Florida, leaving their families hundreds of miles away.

About 90% of Moore's clients have families who live out of state.

The difference between a geriatric care manager and a home health nurse is that the care managers have more time and availability to focus on the whole person and not just the medical issues. The time spent with the client is not restricted by insurance regulation or reimbursement concerns, she says. "Advocacy is a huge part of what we are doing. We coordinate services, manage services, and make sure that whatever services are in place remain appropriate. We are a bridge between the family and the senior. We can be their eyes and ears," she says.

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CMS unveils planned changes to EMTALA

In its final inpatient prospective payment system (PPS) regulations for fiscal year 2007, the Centers for Medicare & Medicaid Services (CMS) has included some "modest" changes to the Emergency Medical Treatment and Labor Act (EMTALA) regulations, says **M. Steven Lipton**, an attorney with Davis Wright in San Francisco. They are as follows:

• **Determination of labor.** Under the current regulations, a physician must certify a determination of "false labor," even if a nonphysician (such as a certified nurse midwife) has made the finding within the scope of his or her license. Changes to the regulation have been requested since its enactment in 1994, and the EMTALA Technical Advisory Group recently made a formal recommendation that CMS modify the rule to meet industry standards.

"At long last, CMS has revised the "false labor" provisions to expand the scope of who may certify the presence of 'false labor,'" says Lipton. "The revised rule will state that a woman experiencing contractions is in 'true labor' unless a physician, certified nurse midwife or another qualified medical person acting within his/her scope of practice (and the medical staff bylaws and state law) certifies, after a reasonable time of observation, the woman is in false labor."

• **Accepting hospital obligations.** Under the current regulations, a Medicare-participating hospital with a specialized capability must accept, within its capacity, an appropriate transfer under EMTALA from a requesting hospital. CMS has interpreted the "accepting hospital obligation" to include all hospitals, including those that do not provide a dedicated ED, notes Lipton.

"The EMTALA Technical Advisory Group recently ratified the CMS interpretation and recommended that all hospitals with specialized capabilities that do not have a dedicated emergency department have the same obligation to accept transfers as hospitals with dedicated emergency departments," he says. "In response, CMS has amended the regulations to state specifically that hospitals without dedicated emergency departments are subject to the 'accepting hospital obligation.'"

Regional referral centers. The final revision to the EMTALA guidelines is a clarification that the reference to "regional referral centers" means rural hospitals that are classified under 42 CFR Section 412.96 as rural referral centers (as opposed to all rural facilities located in rural areas).

The regulations are effective Oct. 1, 2006. ■

Be vigilant when it comes to fraud/abuse compliance

CMs may be responsible if they fail to report

With the Office of the Inspector General (OIG) announcing its intention to cut down on Medicaid and Medicare fraud, it is more important than ever for case managers to make sure that they report any fraudulent conduct and carefully document it to avoid being held responsible, **Elizabeth Hogue**, Esq., suggests.

Government enforcers must prove intent in the case of fraud, but they often cast a wide net that can include case managers in the mix, adds Hogue, a Burtonsville, MD, attorney in private practice, specializing in health care. "If a case manager knew or should have known of a pattern of fraudulent conduct, enforcers may conclude that they had intent, and the courts have backed them up," she says.

When a case manager shows reckless disregard for a pattern of fraudulent conduct, regulators have the necessary information to prove fraud, the courts have ruled. "Fraud is more than just submitting claims for care that the patient didn't receive. Case managers must become vigilant to prevent patterns of fraud and abuse," Hogue says.

Don't be tempted to think that fraud and abuse compliance is the responsibility of hospital management or the compliance officer, she warns.

Under the Medicare/Medicaid Fraud and Abuse Compliance program, every health care practitioner, regardless of his or her position is responsible, Hogue adds.

The OIG has ruled that every health care practitioner has personal and individual responsibility for fraud and abuse compliance, whether they were directly responsible.

"The OIG has taken this position because the OIG realizes that the problem of fraud and abuse will never be resolved until every practitioner takes individual responsibility for it," Hogue adds.

If you notice a pattern of fraud and abuse, report it to your hospital's compliance officer and go up the chain of command to the chief executive office until you get an appropriate response, Hogue advises. Document what you observed and the steps you took in reporting it, she adds.

One of the most frequent examples of fraud and abuse that a case manager might see is a violation of a patient's right to freedom of choice for post-discharge care, Hogue says.

"The OIG has indicated that it is a violation of the Medicare conditions of participation when a hospital discharge planner doesn't give the patient a choice but assumes that the patient would be happy with one agency or another," she says.

Case managers have been held responsible for violation of patients' rights to freedom of choice.

"I've had clients who made reports to a hospital about violations, based on signed statements from patients. The discharge staff were held responsible because they weren't abiding by the Medicare Conditions of Participation," Hogue says.

In the case of post-discharge services, having the patient sign something is not required, but it's a good idea to come up with a consistent way of documenting that the patient is given a choice, she says. "The underlying principle here is that the OIG is always concerned when providers refer patients to the entities in which they have a financial interest. That is at the heart of a lot of the fraud and abuse investigations, especially when patients are 'steered' to entities owned by hospitals without being given an opportunity to choose providers."

A case manager might become aware of services that another practitioner documents that were never rendered to put in a claim for reimbursement. For instance, if a physician claims to have visited the patient in the hospital a certain number of times, the case manager might know better. A case manager might be in the position to observe money or expensive gifts change hands from post-acute providers who want referrals or might be offered gifts themselves.

Case managers can safely accept nonmonetary items of nominal value, Hogue says. "Unfortunately, there is no guidance that is more specific. Case managers should be very careful if they are offered money or gifts. Small gifts, nonmonetary gifts, excluding gift cards and gift certificates, are OK because they are unlikely to produce a referral."

The OIG enforcers are alerted to incidents of potential fraud and abuse in a number of ways, including reports by employees, patient complaints, and routine audits.

Patients are getting more knowledgeable about their right to choose and may indicate that they want a home health agency they have used in the past. "Often, patients have a relative or a friends who works for a home health agency or serve on the board. They alert the patients that they have a choice," Hogue says.

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'Basics' may be pushed aside in rush to trendier remedies

Patient throughput efforts could benefit from DP principles

Discharge planning starts at admission. It's one of the most basic tenets of the discipline, notes **Jackie Birmingham**, RN, MS, CMAC, but one that is increasingly brushed aside as hospitals focus on utilization review (UR) and bed management in an effort to enhance patient throughput.

As health care providers redesign emergency department (ED) processes and cancel elective surgeries in response to the capacity crisis, they often overlook the power of proactive and comprehensive discharge planning, says Birmingham, a veteran discharge planner who now is vice president of professional services for Curaspan Inc., The eDischarge Company.

"Whenever I hear [providers] talking about patient throughput, they sort of [add] 'and, oh, discharge planning,'" she says. "When I listen to patient throughput scenarios, there is talk about bed management tools and ED fast track, and what's happening is that the case manager is spending a lot of time doing UR and not enough time counseling on the patient's readiness for discharge."

Birmingham says she recently came across a situation in which a patient was in the hospital for 10 days, but not until the morning of discharge did staff begin to go over diet and medication issues. At that point, she adds, the family learned for the first time that the patient — who was being treated by several specialists, including a cardiologist and a pulmonologist — had developed prednisone-induced diabetes during the stay and was on insulin.

"I think that the case manager was very involved with getting approval for the nursing home stay and tracking continued stay [criteria]," Birmingham says, "but when it came to the simple discharge plan, that kind of got shunted off."

If UR staff are thinking that a patient is getting close to the end of what will be considered an appropriate hospital stay, she advises, the discharge planner should be actively involved in the process.

"This [concept] is so old — discharge planning rules were proposed in 1986 and passed in 1988," Birmingham says. "But now the admitting staff are looking at what beds are available and predicting how long the patient should be there so they can book the next surgery, and the case manager is looking at the clinical processes that justify the continued stay."

"When it comes time to discharge the patient," she adds, "it seems to be a surprise."

There is a mindset among many patients admitted to the hospital, Birmingham suggests, that they are not going to leave until they are totally independent.

"They don't understand that acute care is a very short part of their episode of care, so they want to stay longer," she says. "It's not all patients, but it's the elderly person with a cardiac condition who has a child [providing care] who might also be elderly with a cardiac condition."

"The fact that patients come into the hospital and are not the way they were before and probably never will be is kind of a shock to the family,"

Birmingham adds. "The family still pictures the hospital as where you go and get better, but it is where you go and get stabilized. [The patient] is like, 'I'm not well enough to go home, but I don't want to go to a nursing home.'"

Meanwhile, she says, the family is not brought up to speed on short-term nursing homes or home health or adult day care.

"In the tweaking of patient throughput," Birmingham continues, "they're not putting enough emphasis on discharge planning. It was intended to move patients. Some people look at discharge planning as writing a plan and being done with it."

She recalls talking to a group of engineers who posed the question, "If discharge planning starts on admission, why does it take so long to discharge a patient?"

What is lost sight of, Birmingham says, is that "discharge planning" is an active term. "It's *planning,* not a *plan.* It's assessing a patient: "If you're going home, well, what do you need to go home? Do you need to see a physician? Do you need equipment? Do you need medications? Do you need to be taught how to test blood sugar?"

Without proper attention to those questions and others, she says, within a short time "the family is clamoring for information, calling the physician back — and the readmission rate from home health care is almost 40%."

"Patients going to a nursing home get a lot more scrutiny than those going to home health care," Birmingham adds. "I'm putting the blame on discharge planners. They may think home care is fairly routine, but it's really risky [for patients] going to an environment where there is not 24-hour care."

A discharge plan is more like a video than a snapshot, she notes. "It's a moving reel, and then you take a snapshot at the end."

"It can be done along with other tasks and fits quite nicely with case management, utilization review, and clinical pathways," Birmingham says. "Capacity management is so important now that a little more emphasis is needed on how you do discharge planning."

The importance of patient choice is another principle that case managers should keep at the forefront of the discharge planning process, says **Jackie Connor**, RN, MS, CCS, director of case management at St. Joseph's Medical Center in Towson, MD.

"In the whole scheme of trying to facilitate discharges rapidly, this has the potential to be

CE *questions*

13. The Centers for Medicare and Medicaid Services has added how many new DRGs to the inpatient prospective payment system for fiscal year 2007?
    A. 32
    B. 20
    C. 13
    D. 25

14. Edward Hospital in Naperville, IL, has set a goal of being in the top 10% in all of the core measures. The most recent data showed they had reached their goal in how many of the 23 measures?
    A. 13
    B. 10
    C. 15
    D. 20

15. How long has Edward Hospital been using a case management model that includes advanced practice nurses?
    A. Two years
    B. Three years
    C. Five years
    D. More than 10 years

16. According to Elizabeth Hogue, Esq., when case managers show a reckless disregard for patterns of fraudulent contact by other clinicians, regulators may charge them with fraud.
    A. True
    B. False

Answer key: 13. B; 14. A; 15. D; 16. A.

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 credit letter. ■

overlooked, she adds. "When you offer choice, give the patient options, it can slow the process down."

Nevertheless, Connor cautions, case managers should not only present available options to the patient but document that choices were offered.

"In a case where a physician wants the patient to go to a skilled nursing facility," she says, "the case manager or social worker may go in and say, 'I have a facility that can take you today, and I can get you all set up.' Certainly patients don't always know they have a choice."

More correctly, she adds, the patient should be told something like, "I have two, or three, or five facilities that have availability."

Medicare guidelines mandate that patients be given choices, not only Medicare patients but any patient, Connor emphasizes. "It's at the heart of the discharge planning process. It's required."

Be alert to 'red flags'

Including orientation, it takes about two years on the job before new case management staff are "fully functional," suggests **Kate Tenney**, RN, manager for case management at Sutter General Hospital in Sacramento, CA. That's the point, she adds, at which they "understand all the red flags that catch their attention, know the resources and how to move patients through the system."

Until about that time, Tenney says, "you can expect that they will miss things." She cites the recent case of a man in his 40s whose face sheet showed that he had Medicare coverage — a red flag that was missed by a novice case manager.

As a result, there was no initial assessment for discharge planning, and the patient — who had a disability, financial problems, and needed a post-acute placement — stayed in the hospital longer than he would have if the situation had been identified sooner, Tenney adds.

In many cases, she says, physicians don't mention those kinds of details, but just say something such as "a 47-year-old man admitted with a broken leg."

"Those little flags are what make or break an effective discharge plan," Tenney notes.

Such oversights can occur even with experienced case managers, points out **Barbara Leach**, RN, director of case management for Sacramento Yolo Sutter Health. They typically occur, she says, "when you're implementing a new software package or putting pressure on meeting criteria — anything that draws you away from doing the same procedure over and over again."

"You could be focusing so hard on InterQual that you get to a Medicare patient and say, 'I don't need to see this one,'" she says. "That's when [cases] fall through the cracks."

Seasoned case managers often have their own system and "bag of tricks" in place, adds Tenney, and are subject to overlooking things when a new methodology is introduced.

"For example, first I open the face sheet, then I look at the first order, then I look at the history and physical assessment," she says, describing her own routine. If management comes in with a new process for staff and says, "This is what you will do and how you will do it," Tenney continues, "it takes away their routine or tricks to identify potential patients that need additional discharge planning or social work."

That disruption can occur, for instance, when the department goes from a written methodology to a computerized one, she says. "You don't necessarily put all those little notes you write into the computer, and that's another opportunity to miss something."

Another frequent challenge to effective discharge planning has to do with knowledge of community resources, Tenney says. "These resources change over time, and we may not be kept abreast of what's available and what's not available."

"I was in a meeting a while back and someone mentioned a nurse who worked for a board-and-care facility," she recalls. "That is very unusual — typically [those facilities] just provide food and a place to live.

"This one not only provides a much higher level of care but has a nurse who works there and gets a higher level of reimbursement," Tenney notes. "We weren't aware that it even existed. Keeping up with what's available in the community is a big problem."

Typically, a case management nurse will put notes on this kind of information in her folder, Leach adds, and the person who covers for her won't necessarily have it. Similarly, she says, "when you transfer a patient from one service to another — say, from the intensive care unit to a med-surg unit — the bag of tricks with the thing that fits that patient might not be there."

Keeping case managers constantly informed of developments in the field — "growing" your staff — is another discharge planning basic that can fall between the cracks, Tenney says.

"With the kinds of caseloads they carry these days, there's not a lot of time to read literature or

periodicals," she notes. "You need people in the organization who summarize what's available and send out tidbits to staff. That's missing in acute care, especially."

While it's hard to calculate the benefit and justify the cost of allocating staff for such a function, Tenney adds, there are ways to address the issue.

One is to look at ways to get staff talking with each other about cases so they're in a position to share their expertise, she says. "One of the things we've tried here is having a huddle with multiple staff — both experienced and inexperienced."

"When you watch them talk, you can see other case managers paying close attention to how someone solved an issue," Tenney continues. "You will see them writing down little notes. If you do it well, you have your senior case managers constantly mentoring new case managers without even thinking about it."

Leach says she holds a team meeting every week that includes case managers, nursing staff, and representatives from other disciplines. Attendees look at difficult cases and "hand off the easy wins from person to person. We've incorporated the ones for difficult patients," she notes, "so now the 'difficult' patients have to be 'very difficult' patients."

"There is a lot of learning that happens in that arena," Leach adds. "We've even brought in experts for, say, tuberculosis care in Sacramento County, and we've had the physician who is the head of health and welfare to talk about the expectation for acute care for patients."

Meetings where information is shared between case managers teaches them how to concisely describe a situation, the problems involved, and their recommendations, Tenney says.

Such gatherings work best if the sharing is kept brief and to the point, she adds. "If they get in the habit of doing that well, it teaches them to dialogue with physicians and nurses. It also allows for other people in the room to come up with ideas that might help them."

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Maryland facility begins 'discharge by appointment'

Plan 'truly' begins at admission

This month, St. Joseph's Medical Center in Towson, MD, will begin discharging patients by appointment, in the latest phase of a three-year effort toward capacity maximization, says **Jackie Connor**, RN, MS, CCS, director of case management.

When Connor was hired in April 2005, she was asked to take over the part of the project that included improving the discharge process, "the back end of patient flow," she adds. "Other teams were working on the emergency department [ED], the front end. We had an issue with 'boarders' in the ED, and as we started collecting data, what came to the surface was that if we could just fix transportation and discharge, 80% of the problem should be fixed."

Connor says her sense of the situation, however, was that a more comprehensive solution was needed. "We put together a multidisciplinary team last June, started working on the problem

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

- Tips for improving patient throughput
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and, as we moved forward, put together subgroups as issues arose."

When the Discharge Task Force was established in June 2005, one of the main goals was to increase the percentage of patients discharged by noon, Connor adds. But even with that specific intent, several months of data collecting revealed little change.

"What we found was that it was causing what we called 'bolus' discharges," she says. "It was a rapid, concentrated effort, a massive amount of patients, trying to get it all to happen before noon."

"Later in the day, we would have 'bolus' admissions as the ED and the catheterization lab would empty out," Connor adds, "so there was not an even workload throughout the day."

That's when the decision was made to move to discharge by appointment, she says. "What we're attempting to do — and I haven't seen this in any of the literature on the subject — is to try to schedule discharge for *all* patients, not just surgical patients."

The idea has been piloted on the surgical unit with some success, and then with interventional cardiology patients, and is now being expanded to all patients, Connor notes. One group that will not be included is the maternal/child patient population, she adds, because there are no throughput issues there. The process works as follows:

1. Planning begins on admission for the anticipated discharge. "I know everybody says they do that, but we truly are going to begin — meaning we will assess the patient, discuss the plan, and then set the anticipated date."
2. Nursing, case management, and physicians work daily on evaluating the plan and the anticipated date.
3. Ancillary departments will be notified of the anticipated discharge date and time and their turnaround of tests and procedures, and their goal is to meet the deadline — to prioritize based on the date given.
4. The patient is informed all along the way of what the plan is.

"We're trying to plan from Day One to get everybody moving in the same direction," Connor adds.

The team will monitor:

- The percentage of patients who have a discharge appointment.
- The percentage of patients who have an appointment who are discharged within 30 minutes of the appointment.
- The percentage of patients who are identified as potential discharges at least 22 hours prior to the actual discharge. ■