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Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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Advocate for cancer patients to help them meet the treatment challenges

Case managers help patients navigate through health care system

When **Nancy Skinner**, RN, CCM, was diagnosed with lung cancer in 2004, she asked her health plan for a case manager to help her navigate through the health care system during treatment.

She was turned down.

"Either I wasn't in the hospital long enough or my costs didn't trigger a referral to case management and they said no. I called on my friends in the case management community who were very helpful to me," she says.

The experience prompted Skinner to speak out in support of case management and other assistance for people undergoing cancer treatment. A case manager for more than 20 years, Skinner is past president of the Case Management Society of American and currently serves on that organization's board of directors. She also serves as a consultant for Riverside HealthCare Consulting in Whitwell, TN.

"Because of that diagnosis and my experiences, I have very much become an advocate for appropriate delivery of care for anyone who has the diagnosis of cancer," she says.

Although Skinner had been managing the care of patients in a multitude of health care settings for many years, she found it difficult to manage her own care.

"When you are diagnosed with cancer, your brain freezes. No matter how smart you are and no matter what your professional background is, there is this, 'Oh my God, I'm going to die factor' that makes it difficult to decide what you should do," Skinner says.

Even people who have spent many years in the health care field find it difficult to navigate the health care system and come up with a treatment plan, she adds.

"It's very easy to get lost in the wilderness. We all need case managers to help us find our way," she says.

It's much easier, as a case manager, to help someone else make a decision about a cancer treatment option than it is to make decisions for yourself, she says.

"There aren't any good maps for patients to follow. We all go on quests for information that sometimes leads to appropriate treatment and sometimes takes us in a direction we don't need to go," she says.

People with a diagnosis of cancer are faced with myriad treatment options, but for the average person, knowing which to choose is very difficult, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president of Mullahy Associates LLC, a Huntington, NY, case management consulting firm.

"People with cancer are looking for information so they can make an informed decision. These people need someone who represents their interests and can help them choose the best option for them. A case manager is a trusted person whose primary focus is the patient and who shouldn't have a vested interest in recommending a particular treatment," she says.

Patients undergoing treatment for cancer are frightened by the disease and by the treatment process. They undergo multiple procedures, often in multiple locations, and the treatment team sometimes doesn't communicate with each other, Skinner says.

"We in health care always talk about the continuum of care but the way our health care system is structured, patients don't see the continuum of care. Health care is separated by buildings, networks, and health plans. Patients are challenged to figure it out in a timely manner so they can get the treatment they need as quickly as possible," Mullahy adds.

Case managers are in a position to assist people with cancer in making choices and to work as an advocate with health care providers, she says.

"Nurses have always been viewed by patients as people who are easy to talk with. They have good communication skills, they are knowledgeable, and they always take the time to listen," Mullahy adds.

Cancer case management can extend from diagnosis, through the course of treatment, and on through survivorship to address the patient's ongoing challenges caused by their cancer treatment, Skinner says. Many patients with cancer don't understand the next step in their treatment plan or what impact the treatment may have on their body and what the side effects may be, she adds.

"Sometimes people turn down treatments, such as radiation or chemotherapy, because they hear stories about the side effects, but there are so many agents available that can eliminate symptoms. Many patients don't know they are out there and often physicians do not have the time to educate them," Mullahy points out.

Case managers do have the time to listen to cancer patients' fears and concerns and when they find out what problems the patients are experiencing, they can communicate them to the treating physicians, she says.

Getting a handle on cancer can be a challenge for patients and case managers because cancer is

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Editorial Questions

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actually a big umbrella of diseases. All cancers have a common pathophysiology but each form of cancer is different, Skinner points out.

Unlike other chronic diseases, which have best practices of care, every case of cancer is different and necessitates an individual treatment plan.

"With diabetes, there are guidelines and decision trees that can be used to determine the course of treatment, which is somewhat similar for everyone. With cancer, the care depends on the type of cancer, the stage, how invasive it is, and what treatment options are available for that particular type of cancer and that particular type of patient," Skinner says.

Case managers have an opportunity to help patients with cancer regardless of settings, Mullahy points out. As a case manager, you should be knowledgeable about cancer resources available in their community and should educate yourself on treatment options and the plusses and minuses of each, she adds.

For instance, find out if there is a center that specializes in cancer treatment. Find out about support groups in the community, and programs, such as the American Cancer Society's Look Good, Feel Better program, Skinner says.

Recognize that the care and availability of certain services may differ depending on the patient's geographical location.

Case managers in all settings typically perform functions such as assessment and planning and that is where they can help cancer patients most, Skinner points out. First, learn as much as you can about the particular type of cancer and help the patient become educated. Look at your client's disease and how invasive it is. Research available treatment options, including clinical trials.

Develop treatment goals. For some patients, the goal is resolution of the disease. For others, it may be palliative care for cancer pain, Skinner points out.

"Don't think that there will be one master plan for every patient with cancer that you can tweak to adjust for differences in the severity of illness. What cancer patients need is a unique plan for their particular disease, based on the ability of the health care system to cure the disease or manage the disease or manage the pain," she says.

Cancer is probably one of the top five diagnoses among members of most health plans, according to Mullahy.

If your health plan doesn't have resources that help you manage the care of cancer patients, advocate for a strong oncology expert to serve as a mentor and a resource for the department, she adds.

If you are a case manager in individual practice, look for help from a nearby medical center, she suggests.

Attend community conferences sponsored by cancer treatment facilities in your area to learn about treatment options that are available, Mullahy suggests.

Learn about cancer web sites with evidence-based information and use them to improve your own knowledge and refer your clients to them as a resource.

Skinner suggests accessing the National Comprehensive Cancer Network (www.nccn.org) web site. "The organization will send patients and health care professionals a CD that includes information on primary cancer diagnoses and evidenced-based guidelines for treatment based on the type and stage of cancer," Skinner says.

If you don't know the answer to a question from a patient, acknowledge that and tell the patient you'll find out the answer, Mullahy suggests.

"Each case manager needs to know his or her own area of expertise and look for help from their peers if they don't know something. It is a disservice to patients to pretend to know something when you do not," Mullahy says.

If you refer your clients to cancer centers of excellence in other cities, help them make the transition back home by ensuring that they have support and expertise for follow up after the acute phase of treatment is over, Mullahy says.

"Many times patients return to their primary care provider for much of the follow up and if that physician is out of his or her element, the patient will not be well served," she adds.

Case managers should continue to address the needs of cancer patients as they move forward, after active treatment, Skinner suggests. Your role at that point may be to help your client come up with a treatment plan that addresses complications from the disease or the treatment, she adds.

For instance, a lot of people experience side effects from the treatment that impact them for the rest of their lives. Make sure the patient understands any complications or treatment side effects and how to minimize them.

Work with the patient and his or her physician to come up with a treatment plan to address can-

cer fatigue, caused by loss of white blood cells during chemotherapy and radiation.

Expect your patients with cancer to be on an emotional rollercoaster, Skinner says. Put them in touch with a social worker or mental health professional if necessary.

"Some days I wanted to cry. Other days I was angry," Skinner says of her experience. "My emotions were up and down." ■

Program helps cancer patients through system

Case managers provide support, resources

An oncology program, launched in January by Cigna HealthCare, provides members with cancer support through diagnosis, treatment, and survival.

Patients who are enrolled in the program receive assistance from Cigna case managers, who are trained in oncology care and who can help them navigate the health care system.

In addition, the Bloomfield, CT-based health plan has partnered with the Lance Armstrong Foundation, located in Austin, TX, to provide support and resources for people living with cancer.

The program builds on Cigna's previous core program of oncology case management, which focused primarily on members in active treatment for cancer with some kind of complication that occurred during their course of treatment, says **David M. Ferriss,** MD, MPH, medical officer for clinical program development for Cigna HealthCare.

"We saw an opportunity and a need to significantly expand the services we provide to members who have a diagnosis of cancer. The new program is a comprehensive program that goes far beyond the original program and includes a whole range of personalized services for people with cancer," Ferris says.

The program focus on all aspects of the disease from prevention to active treatment and survivorship, as well as working with members who need palliative or end-of-life care, he says.

The Institute of Medicine (IOM) has estimated that about half of all men and one-third of all women will develop cancer at some point in their life, Ferris points out.

Members eligible for the program are identified through claims data that may indicate they are being treated for cancer. Other members are identified through self-referral, through disability programs, or when a physician notifies the health plan of medical treatment for a member.

Once a member has been identified as being in active treatment for cancer, he or she is referred to Cigna's dedicated oncology case management team.

A case manager calls the members on the telephone, explains the program, makes them aware that they are eligible for the program, and enrolls members who are interested in participating.

The case manger conducts a telephonic assessment of the member's knowledge about cancer risk factors and overall health. During the assessment, the case managers gather details about the extent of the member's cancer, the member's treatment plan, and the stage in treatment.

The case managers help coordinate cancer patient care and eliminate potential gaps in care. Their support includes helping members better understand treatment options, helping them engage in effective pain and side effect management, educating them on how to best use their health benefits plan, and guiding them to find other resources that support them through treatment, recovery, and survivorship.

"Our goal is to reach these members very early so we will have an opportunity to supply them with the information they need to evaluate their treatment options, as opposed to identifying members when they are already locked into a particular course of therapy. We work to identify members as early in their course of treatment as possible," he says.

The case managers follow up with periodic telephone calls throughout the course of treatment. The number and frequency of calls the case manager makes depends on the needs and wishes of the individual member, Ferriss says.

The case managers help the members access information about their cancer through the Internet and often send them written materials.

Members in the program receive a toll-free number they can call to contact Cigna oncology case managers with questions and concerns.

"As much as possible, members work with a single oncology case manager who is familiar with the member's history and where they are in the course of treatment or survivorship. The case

managers have the ability to share information so that if someone is on vacation or sick, another case manager has the information needed to assist the member," Ferriss says.

Members who have completed active treatment go into a lower stratification but will always have the option to call their case manager with questions or concerns, he says.

Members who have completed active treatment are contacted primarily through mail or e-mail but will always have the option to call their case manager with questions or concerns.

Members in the "surveillance category" have a past cancer diagnosis but are not in ongoing treatment. They receive regular mailings of educational materials aimed to reinforce healthy habits, including maintaining a healthy weight, exercising regularly, and eating a healthy diet.

For instance, women who have been treated for breast cancer but are not in any type of active treatment will receive messages about the importance of regular breast self-examinations and mammograms.

Members in the maintenance program have completed active treatment for cancer but may be receiving medication or other treatment for the residual effects. One example would be a woman with breast cancer who has completed chemotherapy and radiation but is taking an oral drug, such as tamoxifen, for a period of time.

The health plan mines its claims data to identify members who have access to the oncology program as part of their benefits and who have not had a regular screening for breast cancer, cervical cancer, or colorectal cancer. In those cases, the case manager reaches out to them to educate them on the importance of having the tests.

"We are taking it one step further by making proactive calls from case managers, trying to make the patients in the cancer case manager program aware of the benefits of regular screening," he says.

The program strives to support members who have completed their cancer treatment and face the challenges of life as a cancer survivor.

"When people have completed active treatment for cancer, we go beyond urging vigilance and monitoring to make sure there is no reoccurrence or that it is detected at the earliest possible stage. We make sure our members are aware of all the resources pertinent to cancer survivorship," he says.

Members in the cancer case management program receive the Livestrong Survivorship Notebook from the Lance Armstrong Foundation free of charge. The notebook and other materials available through the foundation help individuals cope with the physical, emotional, and practical challenges of cancer. ■

Educating minorities about cardiac disease

Program focuses on African-Americans, hypertension

More than 800 people have been screened and more than 100 are being treated for previously undiagnosed hypertension thanks to a program sponsored by CareFirst BlueCross BlueShield conducted in barber shops and beauty salons in Baltimore's African-American community.

The project, which kicked off in January 2006, is part of the Owings Mill, MD-based health plan's commitment to eliminating racial and ethnic disparities in health care, according to **Jon Shematek**, MD, vice president, quality and medical policy for CareFirst BlueCross and BlueShield.

The program has been so successful that the insurer has plans to replicate it in the District of Columbia.

"We are concerned about the disparities in health care for minorities. Generally, minority patients do not receive the same quality or quantity of health care as non-minorities do. Part of the problem is that health plans don't typically tailor their disease management programs to minority populations. We serve a diverse population and want to ensure that all our members receive the same level of care," Shematek says.

The purpose of the project called Hair, Heart, and Health, is to screen African-Americans for hypertension, to raise community awareness of high blood pressure and the fact that it is a preventable condition, and to educate them on ways to prevent heart disease, Shematek says.

"Hypertension in African-Americans is a killer and it is a silent killer. A lot of times, the first symptoms a person experiences might be a stroke. There can be some very bad outcomes if high blood pressure isn't diagnosed. Many people in the community are not aware that you

don't have symptoms when you have high blood pressure," he says.

The health plan developed the program with the help of **Elijah Saunders**, MD, a researcher and clinician at the University of Maryland School of Medicine, who specializes in heart disease among African-Americans, Shematek says.

When the CareFirst looked for ways to reach its African-American population, Saunders suggested launching the program in barber shops and beauty shops.

"Within the African-American community, barber shops and beauty shops are a place where a tremendous amount of socialization takes place. People may go every week or two for a trim and sit around afterwards and chat with their friends," Shematek says.

People typically develop a close relationship with their barbers or beauticians and feel comfortable discussing personal issues, such as health care, with them, Shematek points out.

"People in the community know and trust their barbers and beauticians. People do speak with their barbers and beauticians about fairly significant matters in their lives," he says

The health plan is collaborating with the Church/Community Health Awareness Monitoring Program (CHAMP), a community-based health care organization, to implement the project.

So far, 11 barber shops and beauty shops in Baltimore are participating in the program.

Barbers and beauticians in the participating establishments have undergone a 12-week training program during which they learned how to take blood pressure and how to provide health information about cardiovascular disease to their customers.

CareFirst funded the training, which was provided by registered nurses who work with the CHAMP organization. The CHAMP nurses make regular visits to the barber shops and beauty shops to monitor the program.

CareFirst has provided each participating shop with a DVD player and DVDs with programming on heart disease and hypertension. The health plan also supplies the establishments with educational materials about healthy lifestyles, including information on blood pressure, cholesterol, diabetes, being overweight, and the need for physical activities.

The barber shops and beauty shops have signs indicating that the staff are certified to do the screenings, he adds.

The screening and educational program is open to anyone in the community and is not limited to CareFirst members, Shematek says.

"Our goal is to increase the health of the community at large. We don't collect any information about membership," he says.

Some of the people screened have insurance and a primary care provider, Shematek says.

If they don't have a physician, CHAMP and CareFirst have provided information about community physicians to the barbers and beauticians.

CareFirst BlueCross and BlueShield has partnered with community organizations to reach two other minority population. The company has partnered with a Vietnamese advocacy and health awareness group in Northern Virginia to promote cervical cancer screenings among Asian women.

The company collaborated with La Clinica Pueblo on a pilot project to find effective ways to improve diabetes care in a Latino population.

In both cases, the company funded health information materials and training for community-based educators to promote healthy behaviors among the minority populations they serve. ■

Communication key to improved documentation

Monitor your outcomes to measure success

Case management involvement in the documentation enhancement process can be limited to monitoring specific DRGs and collaborating

closely with coding specialists to an environment where the case management department has staff whose entire focus is on documentation enhancement, asserts **Lorraine Larrance**, BSN, MHSA, CPHQ, CCM, manager with Pershing Yoakley & Associates, a Charlotte, NC, health care consulting firm.

How involved the case managers are depends on the hospital's philosophy, the other duties of the case management staff, and what the hospital wants to accomplish with the initiative, she adds.

When consultants guide a hospital through the documentation enhancement process, they typically review information provided by the hospital information system, conduct a chart review to validate the data, and identify opportunities for improvement, says **Deborah Hale**, CCS, president of Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK.

"We ask the hospital to select clinical staff, usually nurses, who can be trained to take on the documentation enhancement project. We tell our case management clients that we are not trying to turn them into coders but we want them to use their clinical expertise to help make sure the documentation is clearly written in the medical record," she says.

Training is an important piece in the documentation enhancement process, Larrance points out.

Case managers need to have basic knowledge about coding principles, DRGs, and the reimbursement process to understand why it's important for documentation to be complete, adds **Carol Eyer**, clinical compliance senior manager with Pershing Yoakley & Associates' Atlanta office.

"Without this, the case managers are not thinking along the lines of reimbursement related to documentation in the chart. But with training, they can become the clinical extension to the health information management professionals to ensure that clinical documentation accurately depicts the patient's condition and treatment," she says.

When Eyer trains case managers on documentation enhancement, she presents classroom education, and then follows them through the process on the unit.

Before starting a clinical documentation improvement program, clearly define the scope of the process, and what you are trying to implement, Larrance says.

Identify what you are trying to accomplish, how you want to accomplish it, and where you want to focus, she adds. Clearly define the role of case managers in the process.

Among the options are having a specific group of case managers who do nothing more than documentation enhancement or including it in the duties of every case manager. Set out the relationship between the case managers and the coding staff. Consider whether you want the case managers to be solely responsible for the documentation enhancement piece or to develop a collaborative relationship with the coding staff.

A documentation enhancement program should be geared toward a hospital's payer mix, Eyer says.

"Where to focus on documentation enhancement parallels the same issues as looking at medical necessity or continued stays. Private payers may well have different medical necessity criteria or different agreements with hospitals, but there has to be a basic standard from which to operate," Larrance agrees.

If there is a heavy Medicare population, the program should focus on the Medicare guidelines from the Centers for Medicare & Medicaid Services (CMS). With a larger commercial population, the hospital may choose to focus some efforts on payer-specific guidelines, Eyer says. Many hospitals include patients covered by commercial payers as well as those covered by Medicare in their documentation enhancement projects, she adds.

"Medicare guidelines are often looked upon as an industry yardstick of sorts with managed care payers adopting similar standards," she says.

A lot of commercial payers are beginning to reimburse on the basis of the DRG payment, adds **Doris Imperati**, BSN, MHSA, CCM, managing consultant for Navigant Consulting, a consulting firm with headquarters in Chicago.

For instance, in New York state, many commercial payers are contracting with hospitals based on the Medicare DRG reimbursement schedule, she says.

Imperati suggests that hospitals initially concentrate on improving documentation for Medicare and other DRG reimbursement payers, and then expand the documentation improvement program to include all payers as soon as the Medicare documentation is going well.

"Initially, the improved documentation may only increase the case mix index and not the reimbursement with per diem contracts.

However, if a hospital can show a higher case mix, which reflects increased patient acuity, the hospital may be able to use the higher case mix to negotiate a higher per diem reimbursement contract in the future," she says.

Start with a narrow list of DRGs to focus on, such as the top five problematic DRGs or the CMS core measure DRGs, which are reported as public data, Larrance suggests.

Case managers should educate physicians concurrently, reminding them through queries that written documentation can make a real difference in reflecting the severity of the patient's clinical picture.

"It's not an overnight change. The case managers must reach a comfort level to successfully assimilate documentation enhancement into their responsibilities," Eyer says.

Verbal inquiries to the physician save a lot of time and improve communication between the physician and the clinical documentation specialist, Imperati says.

"Ask them to explain what is going on clinically with the patient and then verbally query for clarification of their documentation in the medical record. It's tricky with compliance once you start putting queries in writing because you can't really have a dialogue about the patient's condition on a piece of paper. You have to always be careful so you are not leading the physician," Imperati says.

Some physicians tell Imperati "just tell me what to write."

This is a no-no, Imperati says.

"I tell them to just think about this case and write what is going on with the patient. I point out that the record should accurately represent the clinical nature of service and the care the patient received and the complexity of the patient's condition," she adds.

Try to steer away from the financial part of the equation when you talk to the hospital's physicians, Imperati advises.

"Otherwise, you're talking money and they're looking at patient care. It's better to keep them focused on documenting what they do for their patients in terms of quality because when the focus is on quality, everything else will fall into place," she says.

For instance, better documentation can improve a hospital's CMS report card, internal report cards, and report cards maintained by commercial payers because the improved documentation more accurately captures the severity of illness and helps to justify the length of stay and resource utilization.

"All doctors will tell you that their patients are sicker. We explain to them that our goal is to help them capture that in the documentation," says Imperati.

Imperati tells physicians that learning what to document in the hospital also can translate into better documentation in their office practice.

"Medicare is heading toward pay for performance for physicians in their office. Documentation improvement in the hospital gets them headed in the right direction," she says.o

Encourage communication

When your project begins, encourage communication between the health information management staff and the case managers so the coders understand the goals and benefits of the program — and that case managers aren't interested in taking their jobs, Eyer suggests.

"Experienced coders often have considerable clinical knowledge and will welcome the opportunity to team with case managers to secure the documentation they so badly need in order to code accurately," she says.

Arrange regular meetings between the case management staff and coding staff to brainstorm on difficult cases and share successes, she adds.

After the training process, the hospital should measure whether the documentation enhancement initiative is making a difference, Hale says.

Monitor the hospital case mix index and top DRGs over time to determine your successes in capturing complications and comorbidities, Eyer suggests. Track physician compliance and physician feedback and communicate them to the appropriate people within the organization, including senior management and physician leadership.

Another way to measure success is to track the rate of the assignment of cases to a certain DRG after the training compared to baseline. The information is reported in your hospital's Program for Evaluating Payment Patterns Electronic Report data but case management directors may find it useful to track the data on a monthly basis, Hale says.

Look at the paired DRGs and track how many you report without complications or comorbidities. If your hospital ranks lower than your state's median, it indicates an opportunity for improvement, Hale says.

"With DRG-based reimbursement contracts, you can measure the financial difference from the moment the chart gets coded if the improved documentation puts the patient into a better-paying DRG," Imperati says. ■

A few words may affect case mix, reimbursement

Ensure documentation reflects patient's condition

When it comes to coding, a rose by any other name may mean that your hospital isn't getting the reimbursement it deserves.

In fact, a few words can make the difference in an accurate DRG assignment and have an impact on the reimbursement your hospital receives, the hospital case mix index, and ultimately how the hospital and the physician fare on public report cards.

If documentation isn't clear or specific enough, it can't be coded at the greatest accuracy. The hospital may receive less than the reimbursement deserved for resources expended on a patient's care because the assigned DRG does not represent the true severity of illness and the level of care, says **Carol Eyer**, RHIA, clinical compliance senior manager with Pershing Yoakley & Associates' Atlanta office.

"Seasoned coders often are able to look at the clinical indicators and recognize what the patient is treated for but they are not able to make leaps in clinical judgment as nonclinicians or make coding decisions when this is not clearly documented by the physician," Eyer says.

Coders are closely regulated from a compliance standpoint and must be cautious not to make clinical assumptions they are not qualified to make, she points out.

Better documentation allows the hospital to more closely reflect the resource consumption of the patient, which is essential since the current DRG system payment rates are based on resource consumption, **Deborah Hale**, CCS, president of Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK.

For instance, if someone comes in with chest pain and the only documentation in the chart is "chest pain," the patient's diagnosis falls into a DRG with a low relative weight. But if the documentation is clearer, indicating angina in a patient with known coronary artery disease, it changes the relative weight and increases the geometric mean length of stay and reimbursement, Hale says.

Surgical patients often represent an opportunity for improved documentation and higher reimbursement by documenting comorbidities and complications, Eyer says.

However, surgeons typically focus on the condition that requires a procedure, rather than the other medical conditions that affect the patient's course of treatment, she says.

But if comorbid conditions or complications, such as congestive heart failure, diabetes, or urinary tract infection, are clearly documented in the chart, it may bump the patient into a higher-weighted DRG, she adds.

"When patients are moved into a higher DRG, the increase in relative weight for that case may be only incremental; but if you have 100 patients, an incremental bump in relative weight can significantly can change the case mix index and can result in more revenue," adds **Doris Imperati**, BSN, MHSA, CCM, managing consultant for Navigant Consulting, a consulting firm with headquarters in Chicago.

In order for coders to correctly assign a DRG to the patient's diagnosis, the clinical terms used by the physician to document the patient's condition must match the current coding definitions issued by CMS, Imperati adds.

For instance, physicians tend to use the term "urosepsis" when a patient has a urinary tract infection and the bacteria leaks into the general vascular circulation, causing septicemia or the lab and vital signs support the diagnosis of sepsis.

"Physicians all over the country call the scenario 'urosepsis' and when they do, the coders cannot represent the true clinical condition of the patient," Hale says.

For coders, "urosepsis" translates to a common urinary tract infection that would not warrant admission to the hospital.

The correct term would be septicemia or sepsis, secondary to a urinary tract infection, Hale says.

Documentation enhancement does not mean misrepresenting that patient's condition or the treatment provided; it clarifies what really happened. In this case, it means that a localized urinary tract infection has developed into a systemic infection, or a systemic inflammatory response to that infection, Hale says.

"In many cases, the documentation in the chart doesn't translate into the patient's severity of ill-

ness. The patient's condition seems obvious to the doctor from a clinical standpoint but it's not so obvious to the coder and it cannot be most accurately coded from the documentation provided," Eyer says.

For instance using the term "type 2 diabetes — poorly controlled" does not qualify for higher severity but "type 2 diabetes — uncontrolled" does, Hale says.

"Physicians learned a different lingo in medical school. Knowing how to document to accurately represent the patient's severity of illness is not education that most physicians get as part of their training," Hale adds.

Sometimes physician documentation actually reflects a better picture of the patient condition than the clinical term used to code the same condition, Imperati says.

For instance, if a patient has blood in the urine, the physician may write "cherry red urine" on the chart so other health care providers have a clear picture of the urine's color at that point in time. Unless the physician uses the word "hematuria" in the documentation, the true condition of the patient can't be coded, Imperati says.

"We work with the physicians and educate them on language that is codeable. In this case, we ask them to use the word 'hematuria' in addition to the description of the urine, which adds further clarification to the color or extent of the hematuria," Imperati says.

Another common coding problem is the documentation of "blood loss anemia," Imperati says.

"There are several different types of anemia but they are not all comorbidities that will bump up the diagnosis to a higher-weighted DRG. Blood loss is a common cause for anemia, but it is often documented only as 'anemia,'" she says.

To be coded as a comorbidity, the anemia must be linked to blood loss using documentation such as "anemia due to blood loss," "anemia due to GI bleeding," or "acute blood loss anemia," Imperati adds.

Physicians often think that the slash mark (i.e., GI bleed/anemia) infers that the conditions are linked. In reality, the conditions can exist independent of each other, which is why documentation has to reflect that the anemia is directly related to the blood loss, she adds.

"Anemia due to blood loss, acute or chronic, is an often-missed complication/comorbidity [CC] and in cases that do not have another CC, this can make a difference in the correct DRG assignment and reimbursement," Eyer says.

The lab values may reveal that the patient has decreased hemoglobin and hematocrit levels and the chart may reflect a transfusion of two units of blood but the physician does not document that the reason for the transfusion was anemia, she adds.

"Coding guidelines indicate that clinical assumptions may not be made on behalf of the physician and this includes interpreting diagnostic test results. The physician would need to document that condition being treated, such as suspected blood loss anemia, before this documentation could be coded as CC," Eyer says. ■

It takes *all* CM functions to provide necessary care

Care coordination 'least recognized'

Many top hospital decision makers still fail to recognize that case management is a core function of patient care, not an optional service that needs to prove return on investment, says **Karen Zander**, RN, MS, CMAC, FAAN, principal and co-owner of the Center for Case Management in South Natick, MA.

Even those who do acknowledge that case management is part of the basic structure of a hospital may not see all of its components as crucial, says Zander.

Hospitals have accepted that utilization review (UR) has "tightened up" so that it is no longer just about having good contracts with payers, but must be practiced on a daily basis and must be done mostly by nurses, she says. "Case managers have to implement the contracts. UR has gone from a blanket, 'We'll get paid, just send this off' to having to explain why we deserve to be paid for this day for this patient."

"If we say, 'This is what we need for UR,' [administrators] wouldn't balk at that, but the functions keep evolving and growing," Zander adds. "If we start with one staff [member], they say, 'OK, we understand,' but then we keep throwing more responsibilities on that staff [member] and the complexity of cases [keeps increasing]."

Having an electronic medical record makes the job of UR easier, she notes. "The problem is that no one has a complete electronic record, so you

have to look at the computer for some information, the paper chart for the rest, and then you have to track down the physicians to see who's covering for whom."

The next most acknowledged case management function is discharge planning, Zander continues. "People know that patients can't live in the hospital for the rest of their lives, so they have an intuitive understanding that discharge planning has to happen.

"They also know that length of stay and getting paid are connected, so there is even more recognition of the importance of discharge planning, and there is a target attached," she says.

"In fact, there are several targets attached," Zander adds. "The more the quality targets rise, the harder the job. It's not just finding a place for the patient to stay, but, [asking], 'Have we done the right thing to prevent readmissions, are we doing the right work in the hospital, and are we sending the person to the right level of care?'"

There are long-term acute care hospitals, but they don't usually take Medicare, she notes, "so you might have a patient who can use that, but has the wrong payer."

The Center for Case Management estimates that 45% of a hospital's medical-surgical patients should be going somewhere besides home at discharge "and we think that [percentage] is low," Zander says. "The recovery phase of [hospital] care got amputated with DRGs.

"What we mean by 'somewhere,'" she adds, "is somewhere where there is nursing oversight and actual nursing care, such as long-term acute care, hospice care, home care. Even one home visit we count."

In actuality, Zander says, most hospitals are at 20% and, with readmission rates on the increase, "will have to ramp up."

The **access** function is the third, less acknowledged, component, she says, "although it has always been a foundation of case management. It is about getting patients connected with health care services, especially the front end of the care.

"That includes getting patients into and through the emergency department; getting them a bed if needed; acquisition of a primary care physician, appointments, transportation, and other resources," Zander adds. "Liaison staff to community agencies are also working in the access function."

The fourth function of case management, care coordination — "the middle of the care" — is the least recognized, she says. "It's about team leadership, treatment planning, and quality, not just what the physicians are doing, but what all the other services are doing in regard to basic care, like pain management and mobility and patient education.

"Are they getting confused? Are they dehydrated? What is their pulse oxygen? Are we mobilizing them correctly? Do they understand how to take care of themselves?"

If caregivers aren't paying attention to those questions, Zander points out, "four days can turn into 40 days. It slips into that very fast if you don't manage those things.

"We have a little poem at the [Center for Case Management]," she notes. "UR is accountability for the *pay,* care coordination is accountability for the *day,* discharge planning is accountability for the *stay,* social work is accountability for the *way,* and access is accountability for today."

If a hospital's executive team doesn't understand all the necessary functions, and how case management will serve those, and if there are no real targets in place to show where a hospital wants to get, Zander says, whatever staffing was allocated at a case management department's inception is likely to remain.

"If social workers did discharge planning and nurses did utilization review [originally], then you are stuck with that unless the hospital sees the access and care coordination issues," she adds. "Unless [administration] sees the scope of what you have to achieve, you get into a fallback position instead of an aggressive one."

(Editor's note: Look for a case management staffing model developed by Karen Zander for the Center for Case Management in the next Discharge Planning Advisor.) ■

COMING IN FUTURE MONTHS

- How community-based case management improves patient care
- Why one insurer integrated its case management functions into regional offices
- How a patient-centered case management model improves outcomes, cuts costs
- Managing the needs of members with rare diseases

CE questions

13. According to Catherine M. Mullahy, RN, BS, CRRN, CCM, president of Mullahy Associates LLC, cancer is probably one of the top five diagnoses among members of most health plan.
A. True
B. False

14. How are members indentified for inclusion in Cigna HealthCare's oncology program?
A. through claims data
B. through self-referral
C. through disability programs
D. all of the above

15. According to Doris Imperati, BSN, MHSA, CCM, managing consultant for Navigant Consulting, it is OK for case managers to tell physicians what to write in patient documentation when prompted.
A. True
B. False

16. The term "urosepsis" is the correct way to document septicemia or sepsis caused by a urinary tract infection in which bacteria leaks into the general vascular circulation.
A. True
B. False

Answers: 13. A; 14. D; 15. B; 16. B.

CE objectives

After reading this issue, continuing education participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how those issues affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities. ■

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. ■