Small Rural Hospital Transition (SRHT) Project Guide

A Rural Hospital Guide to Improving Care Management

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NATIONAL RURAL HEALTH RESOURCE CENTER

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PREFACE

This guide was developed to provide rural hospital executive and management teams with generally accepted best practice concepts. We hope that this guide provides opportunities for considerations to increase performance improvement efforts within their hospital. The guide is also designed to assist State Offices of Rural Health directors and Flex Program coordinators in gaining a better understanding of the best practices so they may develop educational trainings to further assist rural hospitals with performance improvement.

The information presented in this guide is intended to provide the reader with general guidance. The materials do not constitute, and should not be treated as professional advice regarding the use of any particular technique or the consequences associated with any technique. Every effort has been made to assure the accuracy of these materials. The National Rural Health Resource Center (The Center), the Small Rural Hospital Transition (SRHT) Project, Stroudwater Associates and the authors do not assume responsibility for any individual's reliance upon the written or oral information provided in this guide. Readers and users should independently verify all statements made before applying them to a particular situation, and should independently determine the correctness of any particular insert subject matter planning technique before recommending the technique to a client or implementing it on the client's behalf.

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INTRODUCTION TO CARE MANAGEMENT

Purpose of This Guide

Care management is comprised of utilization review and discharge planning and includes processes for the patient's stay as well as post-discharge. Care management has now expanded to include care transition, which is a crucial part of value-based purchasing and future population health management. The purpose of this guide is to clarify best practices in care management. The objective is to help rural hospital leadership gain a greater understanding of care management roles and staffing needs, as well as the responsibilities for utilization review and discharge planning. This guide will also help identify opportunities for process improvement specific to their facilities. Rural hospitals should use this guide to determine how to most effectively staff care management and identify opportunities to improve clinical and financial outcomes. State offices of rural health partners may also benefit by this guide as it assists them to ask the right questions when meeting with hospital leadership.

WHAT IS CARE MANAGEMENT?

Care Management versus Case Management

Care management is fundamentally a collaborative process provided by skilled professionals with multiple outcome focused objectives, which include:

- Providing quality care
- Assuring the correct level of care based on patients' needs, regulations, payor and provider
- Containing cost
- Empowering patients and
- Increasing patient satisfaction

Various nationally recognized health care organizations have similar definitions for case management. In general, "case management is defined as a collaborative process of assessment, planning, facilitation, care

coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcome."[1] [2] However, "care management is an emerging concept that refers to a set of evidence-based, integrated clinical care activities that are tailored to the individual patient."[3] In this guide, care management is the preferred term as it more accurately reflects industry accepted best practices. In contrast, the term case management refers to the patient's situation as a case, which reflects the current fee-for-service system of episodic acute care. As the industry moves towards population health, care management and care transition will require a more holistic approach. Care management and care transition are crucial in the continuum of health care and are becoming even more so both for inpatient and outpatient given the increased need for population health management. According to the American Association of Managed Care Nurses, "care management roles involve coordinated care efforts that manage clients beyond a specific 'case' or 'situation' and provide them with a wide spectrum of services directed at behavioral change, healthy life styles, and optimal outcomes that last beyond the 'episodic' nature of the encounter with the health care system."

Care Management Roles and Staffing Needs

The principles of care management are the same for both Critical Access Hospitals (CAH) and Prospective Payment System (PPS) facilities regardless of the number of beds. What differs however is how the hospital separates the care management roles. Roles under care management commonly include the following key areas:

- Utilization review (UR)
- Discharge planning (DP)
- Swing bed (SB) coordination, when applicable
- Involvement in core measure management

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[1] Case Management Society of America; *What is a Case Manager?*
[2] Commission for Case Manger Certification; *Definition and Philosophy of Case Management*
[3] Doctor's Office Quality-Information Technology; *Care Management Definition*; supported under contract to CMS

- Care transition
- Clinical Documentation Improvement (CDI),which is becoming more common

The care manager is the liaison between the patient/family, providers, the staff and community resources. The success of care management depends on good communication with the patient, physicians (inpatient and clinics), the family/significant other, nursing, therapists, registration staff, the business office director and billers, the health information management (HIM) director and coders, swing bed referring sources, other hospital departments (emergency department/Lab/Radiology, respiratory therapy), payors and community resources.

Organization is a must – it is crucial to have routines and processes in place and to maintain very good records as well as a back-up system. Ideally the roles and responsibilities are assigned to a nurse due to their clinical backgrounds and versatility with any of the duties, as well as their experiences working hand-in-hand with physicians. Most rural hospitals have one care manager, which includes the UR and discharge planning responsibilities and also acts as the swing bed coordinator. Some facilities have a UR nurse and a discharge planner (a nurse or social worker) that are not necessarily placed within the same department. This staffing model is not ideal since it separates the key personnel and care management roles. In rural hospitals where the UR and discharge planning positions are held by two people, both often have other duties such as core measure tracking and abstracting for Centers for Medicare and Medicaid Services (CMS) reporting, and follow-up calls.

Some small rural hospitals with very low inpatient census often use the Director of Nursing (DON) to perform the above functions. Others may use the Med/Surg Nurse Manager as the SB Coordinator while another nurse or social worker (SW) performs the other care management duties. If the hospital employs nurse hospital supervisors (supervisors are usually used for the evening and weekend shifts), these staff members should be trained in utilization review, which allows for an in-house resource that is available 24 hours a day, 7 days a week enhancing the typical Monday through Friday care manager time on duty.

More recently, CDI staff are frequently being added to the team, mostly in PPS hospitals, but are becoming more popular in CAHs. CDI staff positions often report to health information management (HIM), the chief financial officer (CFO) or chief executive officer (CEO). In small hospitals, the care manager may be the one trained in clinical documentation improvement given that they are already reviewing charts on a daily basis and in particular, the physician's documentation to accomplish their UR and discharge planning roles.

A question often asked from CEOs is "How should I staff my care management department?" Unfortunately, there are no simple answers. In general, staffing should be based on inpatient census (includes acute, observation and swing bed) and should consider whether the hospital employs a social worker (SW). If a SW is not available, then the registered nurse (RN) care manager may assume the medically related social service responsibilities. Regardless of the size of the hospital and number of staff, all care management duties must be provided to support operations.

A key staffing consideration is whether the hospital is a PPS hospital or CAH as it relates to swing beds. In a PPS hospital, care management is more time consuming for swing beds since cost containment is crucial and the program requires the completion of Minimum Data Sets (MDS) comprehensive assessments to determine the Resource Utilization Group (RUG) per diem payment for each swing bed patient. MDS assessments are not required in CAHs hence less demanding for care management staff hours.[4][5]

In conclusion, administration should consider the following questions to determine staffing needs to include number of staff and for what hours during the day:

- What is the average daily census (ADC)?
- What times of the day do providers round?

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[4] CMS; *MDS 3.0 for Nursing Homes and Swing Bed Provider*

[5] CMS; *Skilled Nursing Facility PPS*

- Is there a hospitalist model or are there multiple physicians rounding?
- What are the busiest admission days and times of the day?
- Do we have house supervisors?
- Are there sufficient issues to necessitate weekend coverage from home with electronic health records (EHR) or is there enough admissions on weekends to rotate weekend coverage in house?
- What is our back up system to ensure UR, discharge planning and swing bed coordination to cover sick days and vacations?
- What are the responsibilities of the care management staff: UR, discharge planning, swing bed coordination, social work availability or acting as social work designee frequently needed in emergency department, core measure management, involvement in post-discharge follow-up, and accountable to grow the swing bed business with external referrals.

Frequently identified opportunities for performance improvement in care management are as follows:

- Lack of training for the responsibilities
- Silo roles that include staff from different departments that create unnecessary barriers
- Weak UR processes especially for Medicare beneficiaries
- False belief that documentation to support the level of care is not as important in CAHs
- No retrospective utilization review for patients admitted and discharged during when there is no UR staffing
- Lack of management of Medicare patient notifications to be signed by the patient- Important Medicare Message (IMM), HINN letters of non-coverage
- Delayed discharge planning and/or lack of documentation of discharge planning activities
- Shifting of all discharge duties from the nursing staff to the discharge planner causing delays on the discharge day and poor discharges when care management is off duty
- Lack of positive relationship with emergency and inpatient physicians
- Lack of physician understanding of care management roles and responsibilities

- UR staff too black and white or do not want to "tell the physician what to do" hence increasing liability for non-covered days or denials
- Staff hours not conducive to the work load
- Billing for inpatient or observation services even when criteria is not met
- Too many tasks not related to care management
- Poor understanding of the "2 Midnight (MN) Rule" for inpatient versus observation services
- Poor understanding of the 96 hour rule for CAH designation vs condition of payment
- Lack of UR process for after hours and weekend
- Lack of or ineffective post discharge follow-up
- Misunderstanding of required forms to be used for beneficiary
- Insufficient data tracking and trending
- Lack of data analysis for process improvement purpose
- Lack of UR meetings and/or care management involvement in the meetings
- Lack of understanding regarding what population health management and preparation for such means
- CEO who does not respond to the lack of provider compliance (such as lack of history and physical exam (HandP) within 24 hours, frequent social admissions, lack of appropriate documentation to support the daily visits and length of stay (LOS) etc.) due to fear of losing their providers

The Role of Utilization Management or Utilization Review

The term "utilization management" (UM) is often used interchangeably with utilization review (UR). Both involve the review of care based on medical necessity. Utilization review refers to reviews of past medical treatment. It refers to a retrospective review -- the review of treatments or services that have already been administered, and review of medical files in comparison with treatment guidelines. Utilization review includes how physicians' documentation supports medical necessity, as well as ancillary test results and treatments provided. The purpose of utilization review is to ensure that the patient is being admitted or placed in the correct level of care based on

the patient's needs and regulations/requirements based on the payor for the services.

Requests and reviews of appeals also fall under utilization management. Utilization management usually refers to requests for approval of future medical needs. Utilization management is the process of preauthorization for medical service. UR can also be used for the approval of additional treatments while the patient is hospitalized. UR philosophy is to provide the appropriate care at the appropriate time in the appropriate setting for the appropriate length of time for optimal outcome based on resources. This should apply to both hospital and payor UR.

UR nurses work in hospitals, nursing homes and clinical settings where they manage patient care through daily case review. When also assuming a discharge planning role, UR nurses create discharge plans that help patients transition smoothly and safely to their homes or other facilities. These professionals have a significant amount of patient and family contact, as they must often explain the rationale behind their recommendations. They also work closely with insurance companies to ensure that the hospital will be reimbursed for services rendered.

Utilization review should be initiated as close to the time of admission as possible to prevent having to make changes in the level of care assigned to the patient. Ideally, UR has a relationship with the Emergency Department (ED) physicians and the UR staff is called in to consult with the ED regarding the appropriate level of care for the patient whether it be an admission to acute care, observation, swing bed if the patient was discharged from acute care or skilled nursing facility (SNF) for the same reason within the past 30 days, or not meeting criteria for any of those levels. Some hospitals now cover UR seven days a week (weekends / evenings from home given the access to EMR). Given the 2 MN rule, this is less crucial if the physician can determine and document the need for a hospital stay of less or greater than 2 MN which is the determinant for acute vs observation under this rule (see American College of Emergency Medicine – UR FAQ).

Utilization review and management can include concurrent review of documentation to support ICD-10 documentation requirements. As

mentioned previously, some hospitals are adding Clinical Documentation Improvement (CDI) Specialists, or at least providing increased education/training to the present UR staff, given the importance of thorough and accurate provider documentation.

- Improving the accuracy of clinical documentation can reduce compliance risks, minimize a healthcare facility's vulnerability during external audits, and provide insight into legal quality of care issues
- Strong clinical documentation which appropriately captures the patients' medical status including co-morbidities along with efficient coding can improve revenue per discharge
- Clinical Documentation Improvement (CDI) additional information is available online

This guide does not include a comprehensive section regarding population health management but it is important to mention that care management staff should possess a focused awareness of duplication in tests, inappropriate inpatient stays and management of bundled payments etc.

Utilization Review (UR) Best Practice

UR best practice recommendations presented here are intended for small rural hospitals to include those facilities that are minimally staffed with only one person.

- Review demographic information on face sheets of all new admissions
- Determine where to start based on the new admissions payors' requirements (Medicare, Medicaid, commercial payers, payors with managed care, self-pay)
- Review the physician's order for patients in an inpatient bed to ensure that the order for the level of care is very clear:
    - Admit to acute,
    - Place in observation
    - OP service in an IP bed
    - Extended OP in an IP bed
- Ensure the pre-certification notification is completed and documented for payors requiring such

- Determine the certification requirements needs for payors based on priority - (prioritize based on when the information must be reported to the payor)
- Review provider documentation (ED medical record, HandP, progress notes, orders and test results thus far
- Call payor case managers as necessary or use their required electronic form or fax result of review based on payor's requirement – note conversations with case managers and maintain copies of all documentation
- Notify the provider of the certification status
- Review Medicare charts for appropriate criteria to ensure that the right patient is in the right level of care
- If the order is for inpatient, ensure that the provider's documentation supports the need for 2 MN based on presenting medical issues, co-morbidities and risk if discharged (signed certification is no longer required)
- Medicare reviews include the following:
    - Ensure that the Medicare patients have signed the Important Medicare Message (IMM) letter on admission and provide if it wasn't
    - Observation lasting greater than 1 MN but less than 2 MN when counting midnight spent in OP by the time of UR – Options are:
        - Discharge if stable. (Continue workup on an OP basis if needed) or
        - Continue observation status if medical necessity is still relevant but plans are to discharge the patient before the second midnight or
        - Admit – Admitting physician to document medical necessity for the need of 2 MN or greater including the midnight spent in OP. Provider to document why the patient cannot be discharged which will lead to medical necessity documentation for admission or
        - Convert to outpatient in a bed (OPIB) and stop observation billing (e.g., patient stable but waiting for a test to be completed – such as the mobile MRI will only be on site the next day) – This should be prevented if at all possible since there is no reimbursement for OPIB. When otherwise

stable, the patient should be discharged from observation and asked to return later for the MRI

- Ensure that the observation patient is aware of their level of care – Written notification of observation status is recommended to prevent misunderstanding from the patient/family
- Review the chart for physician's certification of the 96-hour expectation for all generic Medicare patients
- Work with the physicians to change the level of care if appropriate (inpatient to observation or vice versa)- Use Medical Director/Advisor review if applicable and document
- Notify the patient/family of change of status if patient was an inpatient and was changed to an observation status – written notification is recommended to prevent misunderstanding from the patient/family
- The UR manager or designee should be available to discuss the physician's plan as much as possible during the am rounds
- For patients placed in observation, the UR manager should:
  - Confer with the day charge nurse before leaving to discuss patient status etc.
  - Touch base with the primary care physician (PCP) before leaving for the day and discuss the next step (discharge before midnight or be admitted)if not determine by this time
  - Share discussion with the house supervisor or the evening charge nurse to ensure that all parties are on the same page

- Document UR findings - reasons they meet criteria or do not meet criteria
- Provide letter of non-coverage if not meeting any criteria. See CMS website for more information regarding HINN letters
- Review of chart on a daily basis to ensure that patient continues needing inpatient stay and discuss issues with the provider and manage the length of stay. Using the InterQual or Milliman Roberts Guideline is recommended for post 2 MN stays.
- Provide retrospective review of those admitted and discharged during UR time off and discuss with business office if lacking the required documentation to bill for the level of care the patient was in

    - For instance, we cannot knowingly bill for observation or inpatient if the patient was a "social admit"
    - If a patient was inpatient but only met criteria for observation or regular outpatient, billing may change the status and bill outpatient services in an inpatient bed (up to 1 year)
- Ensure that the patient receives the discharge IMM letter. See website for sample policy and procedure (PandP) regarding IMM
- Track and report UR data to administration and the medical staff
- Participate in the revenue cycle meetings

Utilization Review Data Tracking

Data tracking is used to manage resources as it is for any other departments. Utilization is continuously tracked to have a finger on the pulse of business. All other data is used to determine opportunities for improvement. If there are obvious issues, data tracking can help identify root-causes and should be tracked and reported on a monthly basis. If numbers are low, data can be reported on a six month basis. Refer to Appendix A for a list of key UR management indicators that should be tracked and monitored to determine opportunities for improved management and prevent costly denials. See Appendix B for a self-assessment regarding UR management practice and processes

The Role of the Rural Hospital Discharge Planner

Center for Medicare and Medicaid (CMS) the Condition for Participation (CoP):

§482.43 Condition of Participation: Discharge Planning
"The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing."

Interpretive Guidelines §482.43
Hospital discharge planning is a process that involves determining the appropriate post-hospital discharge destination for a patient; identifying what the patient requires for a smooth and safe transition from the hospital to his/her discharge destination; and beginning the process of meeting the patient's identified post-discharge needs. Newer terminology, such as "transition planning" or "community care transitions" is preferred by some, since it moves away from a focus primarily on a patient's hospital stay to consideration of transitions among the multiple types of patient care settings that may be involved at various points in the treatment of a given patient. This approach recognizes the shared responsibility of health care professionals and facilities as well as patients and their support persons throughout the continuum of care, and the need to foster better communication among the various groups. Much of the interpretive guidance for this CoP has been informed by newer research on care transitions, understood broadly. At the same time, the term "discharge planning" is used both in Section 1861(ee) of the Social Security Act as well as in §482.43. In this guidance, therefore, we continue to use the term "discharge planning."

When the discharge planning process is well executed, and absent unavoidable complications or unrelated illness or injury, the patient continues to progress towards the goals of his/her plan of care after discharge. However, it is not uncommon in the current health care environment for patients to be discharged from inpatient hospital settings only to be readmitted within a short timeframe for a related condition. Some readmissions may not be avoidable. Some may be avoidable, but are due to factors beyond the control of the hospital that discharged the patient. On the other hand, a poor discharge planning process may slow or complicate the patient's recovery, may lead to readmission to a hospital, or may even result in the patient's death.

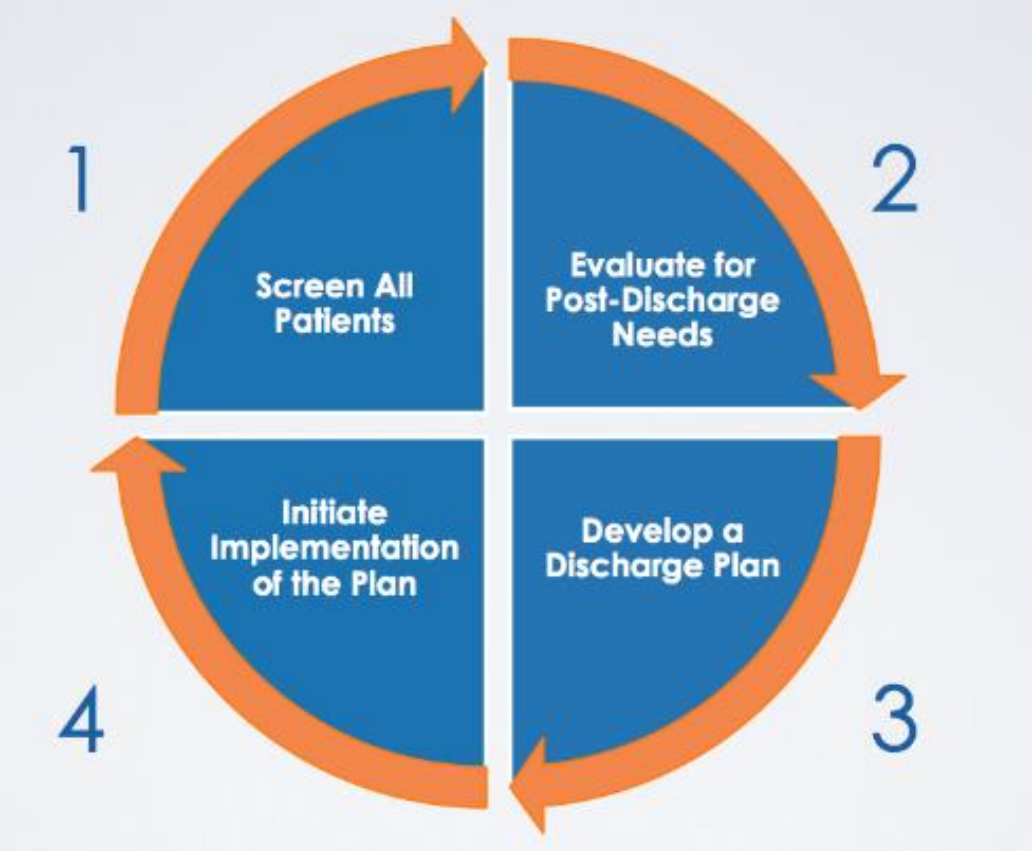
The discharge planning CoP (and Section 1861(ee) of the Act on which the CoP is based) provides for a four-stage discharge planning process (see Figure 1 below):

- Screening all inpatients to determine which ones are at risk of adverse health consequences post-discharge if they lack discharge planning

- Evaluation of the post-discharge needs of inpatients identified in the first stage, or of inpatients who request an evaluation, or whose physician requests one
- Development of a discharge plan if indicated by the evaluation or at the request of the patient's physician; and
- Initiation of the implementation of the discharge plan prior to the discharge of an inpatient.

The hospital is required to specify in writing its discharge planning policies and procedures. The policies and procedures must address all of the requirements of 42 CFR 482.43(a) – 482.43(e). The hospital must take steps to assure that its discharge planning policies and procedures are implemented consistently."

Figure 1. Discharge Planning Process



Discharge Planner Responsibilities?

In best practice facilities, the discharge planner's responsibilities include the following:

- Review nursing discharge planning documentation incorporated in the nursing admission assessments within 24 hours as much as possible to serve as a screening tool
    - If the hospital does not have a policy to implement the discharge planning process for all patients, then the PandP must identify in which cases it is to be implemented.
        - In rural hospitals, it is customary to complete a discharge planning assessment for all inpatients due to lower census
        - Unless done in an organized fashion, and if left to the bedside nurse, it is difficult to have positive outcomes on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey regarding discharge planning and transition of care. See HCAHPS questions March 2015: Discharge Information Composite (Q19, Q20) and Care Transition Composite (Q23, Q24, Q25) for more information
- Consider rounding with the physicians since this most often proves to be very beneficial. If more than one provider rounds at the same time, someone else may also be assigned to round but then it is important to huddle and discuss outcomes of the rounding
- Visit with the more complicated patients and those that are known to probably need a post-acute program first
- Call families of those not available at the hospital as needed - Document all visits and calls to family
- Document assessment and findings
- Address Advance Directive
- Discuss discharge needs regarding durable medical equipment (DME), Home Health, skilled care, long term care (LTC), hospice etc. with the provider as soon as possible to ensure efficient and timely discharges
- Ensure process for correct documentation of discharge disposition and have a mechanism to change and notify other providers as needed
- Facilitate discharge planning meetings on a daily basis for acute patients and weekly for swing bed patients

- Call home health and nursing homes within 12 to 24 hours post discharge to ensure that all orders were understood and there are no new issues – role may be deferred to the unit's nurse manager or designee.

Discharge Planning Data Tracking

Data tracking regarding discharge planning and disposition is also important to identify what is done well and what are the opportunities for improvement. Refer to Appendix C for the Discharge Planning metrics. See Appendix D for a self-assessment regarding Discharge Planning processes.

CARE TRANSITION

What Is Transition of Care?

The term "care transitions" refers to the movement of patients between healthcare settings/facilities (inpatient and outpatient, home with home health, nursing facilities and practitioners including PCP and specialists) as their condition and care needs change during the course of a chronic or acute illness.

Hospitals have become very interested in care transitions programs because of the following:

- CMS is leaning on hospitals to lower their preventable readmission rates
- PPS hospitals pay a penalty if readmission rates are too high
- There is a potential decrease in patient satisfaction
- High preventable readmission rates are costly and may deter potential partners or affiliates
- Last but not least, it's the right thing to do

There are multiple issues that lead to the need of improved care transition such as:

- Patients with chronic illnesses are often confused about who they should see for what
- Last minute or poor discharge instructions from the hospital create further confusion
- Patients might be referred to as "non-compliant" versus the need for staff to take the time to assess the situation and provide appropriate resources
- Medication errors involving misunderstanding of instructions, medication adherence, drug-drug interactions and duplicate prescriptions may occur
- Patient might stop medication due to perceived side effects or finances
- There is poor follow-up with PCP
- No follow-up appointments are available for one to two weeks post discharge
- There is no availability of appointments for one or more weeks when a patient calls with concerns
- There is no follow-up with specialist
- There is a lack of knowledge about alternatives such as home care providers, hospice, palliative care
- There is a lack of understanding of who the patient /family should call and/or where they should go if issues arise – misunderstanding of the use of the emergency room
- There is a silo or non-team approach to care and providers (hospitals, home health, nursing homes, physicians, EMS, Area Agency on Aging etc.) are "doing their own thing" and giving different handouts with instructions for same diagnosis.

Care transitions programs allow hospitals to focus on reducing readmissions and improving overall health care conditions by:

- Improving discharge planning processes
- Improving patient education material and explanation of such
- Use of "Teach Back" method for patient/family teaching

- Use of Discharge Timeout
- Strong process for medication reconciliation
- Making PCP follow-up appointment before the patient leaves the hospital
- Implementing follow-up calls to determine outcome, how the patient is doing, can the patient verbalize the discharge instructions, did the patient fill the new prescription(s) and if not, why not, do they have transportation to their PCP or specialist visit etc. and other general and specific information based on diagnosis and locality

More frequently, we now see increased follow-up for at least one month via weekly follow-up calls or more often for those with chronic diseases and/or if the patient is at risk for readmission. During the follow-up calls the patient/family can be assisted as needed and the caller can become the liaison between the patient and their PCP. Others sometimes coordinate extra support by getting a social worker involved. Findings from the follow-up calls are shared with their providers. Some have added the home visit for more concerning patients within a few days post discharge and on a weekly basis or less based on needs to assess the home situation and assist the patient with their care transition (especially if they do not meet home health criteria).

The implementation of Personal Health Records (PHR) has also proven to be effective by involving the patient, their families/significant others and their providers. Patients use their PHR to track information about the care they receive across settings. They are encouraged to record information about any chronic health problems, increased sign and symptoms specific to their diagnosis, visits to each healthcare setting, dates they were treated, what they were treated for, what type of medications they take, the dosages associated with those medications, complaints regarding their medication etc. The PHR coupled with empowering patients and their caregivers to advocate for themselves has increased patient involvement in managing their own health. This requires working with providers to break down the silos of communication as well as patient/family education and provision of tools.

Others yet have implemented a Care Transitions Intervention Model such as the one developed by Dr. Eric Coleman. Dr. Coleman was successful in reducing Colorado area hospitals readmission rates by 35-50 Percent by implementing programs where health or transition coaches are assigned to patients.

Also see the following website for an issue from the California Healthcare Foundation, titled "Navigating Care Transition in California – Two Models for Change" where you will read about the Four Elements of the Coleman Care Transitions Interventions: (1) Medication Self-Management (2) Patient-Centered Health Records (3) Primary Care Provider/Specialist follow-up and (4) Knowledge of Red Flags. See Appendix E for a self-assessment to determine your level of participation in helping patients with their transition of care.

CONCLUSIONS

This care management guide was developed to provide rural hospital executive and management teams a practical approach to understanding care management as well as serving as a resource to the staff members who hold those positions by starting with a self-assessment to determine opportunities for improvement (See appendix B and appendix D). The guide should increase awareness of the management team as to the purpose, roles and responsibilities of care management and serve as a how-to for managing all inpatient components of care management which is crucial for:

- Revenue management and decreased vulnerability as a result of strong utilization management process and components of a CDI program.
- Maintaining compliance with CMS through chart reviews and discharge planning processes.
- Grasping the purpose of care transition to ensure good outcomes such as decrease readmission rates and inappropriate use of the ED through:
    - Strong IP discharge planning processes;
    - Increased patient/family engagement;
    - Implementation of a follow-up program from phone calls to home visits to community coach training.

In summary:

- Effective care management requires the CEO's and Board of Directors' support to manage utilization review within guidelines and regulations to remain compliant.
- Staff in these roles require training and the possession of right work ethics and personality to work and influence a variety of people (patient/family, IP and OP physicians, referring hospitals' discharge planners, community resources etc.).
- Utilization management is crucial to prevent denials and maintain compliance.

- Cost management is important for fee-for-service systems for both Medicare and payor Managed Care admissions and will increase when managing a patient within a bundled payment, and even more so for admissions under an Accountable Care Organization (ACO) or the likes.
- Some level of clinical documentation improvement process is very important for both PPS and CAHs to optimize payment and support the level of care.
- Discharge planning is needed for every patient but at different levels based on a screening or assessment but must be face-to-face to include an explanation of what the discharge planner is doing (somewhat scripted) in order for the patient to recognize the HCAHPS questions regarding two composites: Discharge Information and Care Transition.
- Follow-up processes are no longer simply a "nice thing to do", it becomes imperative under the Accountable Care Act (ACA) and Population Health Management.
- Utilization Review meetings with meaningful data to be shared with the medical staff as well as participation in revenue cycle meetings and applicable process improvement projects is a must.

APPENDICES

Appendix A: Utilization Review Management Data Tracking

- Acute admissions and days/month per service line (Acute, ICU, OB, Swing Bed, IP and OP surgeries, OP procedures in an IP bed such as blood transfusion, OP IV hydration etc.)
- Total acute average length of stay (ALOS) and Medicare ALOS for acute care
- Swing Bed ALOS
- Observation admission and days/month as well as ALOS
- Observation days is total number of hours in a month divided by 24
- Days in overage
- Medicare patient and hours per days above the 96 hours condition of payment (CoP) for CAHs
- Days above the Geometric Mean Length of Stay (GMLOS) for PPS hospitals (Total and by key diagnosis based on frequency)
- Monthly status of the ALOS in relations to the 96 hours by fiscal year end (FYE)– CAH CoP
- Number of admissions supported by documentation and number not supported by documentation by providers at time of admission
- Number and percent of patients in observation who were changed to inpatient (IP) (total and by ED and IP physician)
- Number and percent of patients admitted as IP, but had to be changed to observation (total and by ED and IP physician)
- Number and percent of above meeting Condition Code 44
- Percent of patients placed in the right level of care when initially admitted

- Number of patients and days patients did not meet acute or observation criteria (total and by physician)
- Number and percent of reviews done post-discharge
- Number of unbillable days/month
- Number of acute IP with 1-day stay due to being placed in observation then requiring a 2nd midnight creating a 1 day IP stay
- Number of observation discharges who returned to ED and/or observation or Acute IP within 7 days and within 30 days (purpose is to determine if they should have been admitted the first time around or D/C plan was not sufficient)
- Number of acute IP admission with a 3-day LOS and discharged to SNF/SB on day four (4). This indicator is especially important for PPS hospitals since it may impact revenue if it is less than GMLOS or may be a red flag for the FY/MAC due to fear of optimization of the PPS payment when the patient still met acute criteria.
- Medicare/RAC denials by service line, payor, and total amount, and more specifically denials due to lack of medical necessity
- Percent of admissions who did not receive the IMM notification pre or on admission
- Percent of discharges with a greater than 2 day stay without receiving the 2nd IMM letter

Appendix B: Utilization Review Assessment

Do We Have Best Practices With Regard To Utilization Review Processes?

- Do we have a good relationship with providers in a way that I can influence them to do the right thing for the patients and maintain compliance with CMS and payors' regulations/requirements?
- Do we have a close working relationship with the coder to discuss documentation findings/needs?
- Do we have a good understanding of the 96 hr ALOS CAH rule for CoP vs the 96 hr LOS for CAH condition of payment from Medicare?
- Do we understand the impact I can have in managing the GMLOS under PPS
- Do we understand the 2 MN rule?
- Do we have a good grasp of how to determine IP vs observation criteria?
- Do we understand Condition Code 44 and what is required to apply it?
- Do we know how to use the guideline manuals (ie: InterQual, Milliman Roberts) when necessary?
- Do we have a good working relationship with the discharge planner or UR if that role is held by other than me?
- Has the hospital assigned a UR Medical Director or Physician Advisor and back-up?
- Do we know when to consult with UR Medical Director or Advisor?
- Are we well organized – good documentation and efficient filing system?
- Do we know what to track and analyze in order to identify opportunities for improvement?

- Do we schedule hours based on workload and not based on the individual UR and Discharge Planning PandPs that were written a long time ago and may no longer be appropriate?
- Do we have a binder with names of payors, contact person, what each payor expects, per diem when applicable?
- Have we made a task list for others to allow continued coverage during my vacation or unexpected days off?
- Do we have documentation to support decisions regarding level of care?
- Do we ensure timely signatures to be obtained (admitting and discharge IMM, 96 hr certification for CAHs, HINN notices)?
- Do we ensure that the patient is aware of the level of care they are in preferably using a letter to the patient when placed in observation or changed from IP to observation status post admission?
- Do we attend the internal coding training to improve my knowledge of documentation needs especially with ICD-10?
- Do we have a close working relationship with the billing office?
- Have we provided house supervisors, ED physician and staff training regarding IP vs observation and the 2 MN rule?
- Do we facilitate effective Utilization Management meetings?
- Do we remain compliant with mandatory notices?
- Are we involved in Medicare chart requests/denials and learn from it?
- Do we monitor CMS website on at least monthly basis and/or have signed up for list serves?
- Do we know how to reach the QIO and how to involve them as needed?

Appendix C: Discharge Planning Data Tracking

Data tracking regarding discharge planning and disposition is also important to identify what we do well and what are the opportunities for improvement.

- Disposition status (Percent to home, SNF/SB, ARU/IRF, transferred to another acute care facility…)
- Readmission rate by diagnosis and PCP
- Readmission rate from long term care (LTC) or Home Health (HH) as well as Percent of readmissions from which facility or HH
- Outcome of readmissions by potential reason(s) for such as:
    - Did not understand medication and did not take as planned
    - Did not understand special instruction for self-management
    - Did not follow-up with PCP
    - Did not pick up prescription due to financial issue
    - Did not pick up prescription due to unpleasant side effects
    - Transportation issues
    - Social issues – patient admits he/she continued smoking, drinking, not following diet etc.
    - Support system fell apart
- Readmission from NH or HH because PCP automatically sent patient to ED
- Other specific to locality

Appendix D: Discharge Planning Assessment

Do We Have Best Practices With Regard To Discharge Planning Processes?

- Do we make time to introduce ourselves as the discharge planner on the day of admission or at least within the next work day?
- Do we give them a business card with name and contact information
- Do we take the time to sit with the patient/family and explain that we are meeting with them to discuss whether they will have the help they will need when they leave the hospital (including transportation and financial support)?
- Do we explain options for discharge and take their preferences and those of their family or caregiver into account in deciding what their health care needs would be when they leave the hospital?
- Do we have a discharge planning documentation form to ensure all information is addressed? (Psychosocial needs, support, financial needs etc.)
- Do we have a process to discuss Advance Directive and documentation of such and/or obtain a copy for the medical records from those who have an advance directive?
- Do we round with the provider(s)? If not, do we huddle post rounding to discuss all information gathered?
- Do we discuss discharge needs, plans and options with the provider within the 2nd day of admission including plans for post-acute care needs?
- Do we ensure that the patient has a timely follow-up appointment with their physician post-discharge?
- Is our documentation available to the team (physicians, nurses, therapists)

- Have we implemented a daily interdisciplinary discharge planning meeting (IDT) that is short, concise, informative, and efficient?
- Does our hospitalist (when applicable) participate in the IDT meetings?
- Do we complete a risk for readmission assessment to strengthen the potential for sustainability and prevent readmission?
- Do we complete a readmission assessment for those unplanned within 30-day readmissions to identify opportunities for improvement as to what we could have done differently?
- Do we touch base with patients on the day pre or day of discharge to ensure that their discharge needs have been met and that the patient/family feels comfortable with the post-discharge plan(s)?
- Does the patient discharge nurse use a Discharge Preparation Checklist to ensure that the patient/family feels comfortable with their readiness for discharge (also referred to as a Discharge Timeout)?
- Do we have a strong patient education process with handouts that are easy to understand and follow?
- Do we have a strong medication reconciliation process?
- Have we created a booklet of all community resources which patients/families and community residents can use as a tool to assist them in managing their needs? – This should also include non-medical resources: church programs, meals-on-wheels, low drug cost program, shelters, food bank etc.
- Do we have a good process in place to ensure that the documentation of the discharge disposition is correct as required by CMS?

Appendix E: Care Transition Assessment

What Processes Can We Implement Today to Improve Care Transitions?

Transition of Care starts with discharge planning from which we build upon.

- Have we met with the PCPs in our service area to discuss their needs regarding patient care management?
- Do we tabulate the information obtained from readmission assessments and post-discharge follow-up calls or visits to help identify needs?
- Have we created a focus team made up of providers in the community: hospital, IP and Retail pharmacists, home health, nursing homes, Area Agency on Aging, Hospice, EMS, public transportation, Assisted Living, Care Homes etc. to discuss common issues and needs and brainstorm recommendations and develop action plans?
- Have we created a Patient Health Record and agreed on its use across the board with commitment by providers to assist the patients/families in maintaining it up to date?
- Do we have clear and concise chronic disease specific instructions that are the same across the continuum of care?
- Have we vetted our education material using a sample of our own patients?
- Have we implemented a process for medication reconciliation that includes the patient/family, the PCP, the local pharmacists, the specialists, the hospital, the NH and HH?
- Do we call HH and NHs within 24 hours post hospital discharge or ED visits to discuss the patient's status as well as review and clarify all orders?
- Is there any staff at the hospital whose duties and time (at least part time) can be reallocated to making the follow-up calls (post discharge and weekly as needed), home visits as needed for those not qualifying for HH?

- Have we considered a foundation for those in need to be provided with scales, B/P cuffs, medication etc.?
- Have we looked for grant opportunities to fund chronic disease management program, purchase a transportation van, training health coaches etc.?

REFERENCES

The Case Management Society of America

American Case Management Association

National Transitions of Care Coalition

Joint Commission- Hot topics in health care

Discharge Planning Association

Agency for Healthcare Research and Quality- Care Transitions