

# **From Hospital to Community: Changes, Challenges and Solutions in Case Management**

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**Amy Smith, RN, MSN, CCM**  
**Director of Care Management**  
**Dartmouth-Hitchcock**

# Agenda

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- Welcome and Introductions
- Learning Objectives
- **Amy Smith**, RN, MSN, CCM, Director of Care Management,  
Dartmouth-Hitchcock
- Question and Answer Session

# Audience Notes

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- There is no call-in number for today's event. Audio is by streaming only. Please use your computer speakers, or you may prefer to use headphones. There is a troubleshooting guide in the tab to the left of your screen. Please refresh your screen if slides don't appear to advance.
- Please use the "chat" feature below the slides to ask questions throughout the presentations. We will pose questions after the presentation and will address as many as time permits.
- A recording of today's session will be posted within one week to the Commission's website, [www.ccmcertification.org](http://www.ccmcertification.org)
- One continuing education credit is available for today's webinar only to those who registered in advance and are participating today.

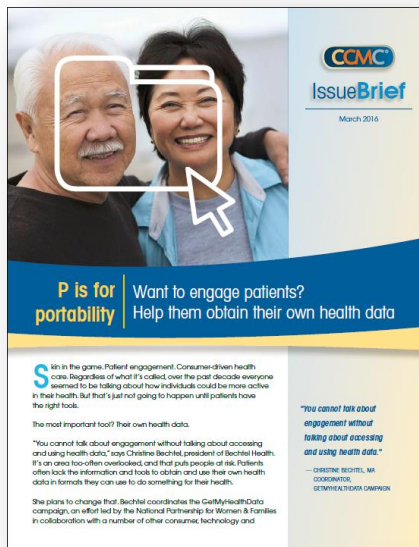
# Learning Objectives Overview

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*After the webinar, participants will be able to:*

1. Describe recent changes in Medicare rules and reimbursement that affect case managers in the hospital and clinically integrated provider settings;
2. Discuss the relationship between care coordination and accountability within an collaborative system of care; and;
3. Outline the challenges/barriers to accountable care that remain for case management programs.

- Webinars
- Certification Workshops
- Issue Briefs
- Speaker's Bureau



# A journey to more accountable care

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READMISSIONS



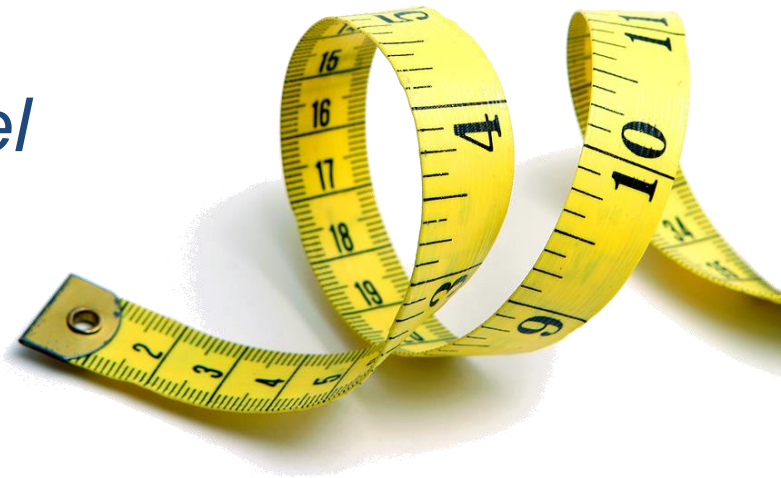
ACA

# ACA-inspired trends on the rise

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- New team-based, collaborative models challenge the status quo and old pecking order
- Stronger emphasis on data, measures, quality improvement
- Focus on reducing fragmentation, easing care transitions, preventing unnecessary readmissions
- New roles, new people in the mix: Data and quality analysts are paying more attention to case managers

*Increasingly, case managers feel the need to quantify their value and the value of their work.*



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# Dartmouth-Hitchcock



# Dartmouth-Hitchcock by the Numbers



DHMC Lebanon, NH



Bennington, VT



Concord, NH



Keene, NH  
(D-H Keene/Cheshire Med.  
Ctr.)



Manchester, NH



Nashua, NH

Discharges	25,700
Outpatient Visits	1.7 M
Births	1,150
Operations Performed	19,700
Emergency Dept Visits	31,000
DHART Medi-flight	1,300
Volunteer Hours	25,000
Total Employees	9,302
Physicians	1,032
Residents/Fellows	393
Annual Revenue	\$ 1.3 B
Community Benefits	\$ 268M



*Staying Current  
With the Changes*



# Two-Midnight Rule

- August 2, 2013, CMS published the 2014 IPPS final rule
- The two-midnight rule mandated that physicians order inpatient admissions based on expectation of greater than two-midnight stay
- The rule was slated to go into effect October 1, 2013 and was delayed twice
- **The final OPPS rule went into effect January 1, 2016**



# Two-Midnight Rule

- **Inpatient Status**--physician expects the patient to require care that crosses two midnights and orders admission based upon that expectation
- **Outpatient Status**--when the physician expects the patient to require care for less than two midnights

**Current Rule**--Hospital stays less than two-midnights are processed/paid as outpatient

# The “Why”

- In 2012, the CERT (comprehensive error rate testing) contractor found that Medicare incorrectly paid hospitals in 36% of inpatient admissions lasting 1 day or less. For 2 days the rate dropped to 13.2%, and for 2 day stays the improper payment rate was 13%
- In addition, Medicare noticed their beneficiaries who were placed in OBS instead of being admitted were increasingly staying for more than 48 hours. In 2011, 11% of patients stayed in OBS 48 hours or more



# CMS-Changes on 10/1/15

- CMS resumed short-stay audits after September 30, 2015. This means every admission starting October 1, 2015 is subject to audit.
- Audits of Medicare short inpatient admissions will be performed by Livanta and KePRO, the Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs), instead of the MACs.
- Admissions for patients who spend less than two days as inpatient are subject to audit.



# What do these changes mean?

- Group of health quality experts with a mission to improve the effectiveness, efficiency, economy and quality of services delivered to beneficiaries
- No incentive to deny because the QIO is not compensated this way
- The QIOs will review for medical necessity on less than two-midnight stays
- Referrals may be made from the QIOs to the RAs due to “high error rate”





# Two-Midnight Rule and the Impact to Observation



# Changes to Medical Observation

- The OBS payment for hospitals increased, this means that the visit is comprehensive and the payment covers the ED visit, the OBS hours, and all billable services.
- The change to bill from each service to a comprehensive bill will make efficiency in providing care to patients that are “in observation” even more important than before.
- Observation stays can no longer incur greater out of pocket costs for the patient, than those charged for an inpatient deductible



# Medical Observation

- Expectation of MD that medically necessary hospital care will require a stay less than 2 midnights
  - Midnight counting begins when symptom-related care beyond triage starts
  - OBS hour counting begins when order is written, but two-midnight counting begins when care starts
  - Any practitioner with privileges to order services can order observation (not an inpatient)



- The Notice of Observation Senate bill H.R. 876, Treatment, and Implication for Care Eligibility (NOTICE) Act was implemented August 2015 requiring written and verbal notice to all observation patients within 36 hours of being placed in observation care.
- Notice must explain to patients, in plain language, that they have not been admitted as an inpatient, the reasons, and the financial implications.

# Observation after Surgery

- The guidelines around the Observation for post-procedure patients hasn't changed much in light of two-midnight rule, but still challenging to manage from a compliance standpoint
- CMS rarely pays the hospital anything additional for observation stays post-op
- CMS continues to require hospitals to report the use of observation but will continue to bundle the costs into the payment for the procedure

# Observation After Surgery

- Observation should only be ordered if additional monitoring is needed after the “normal recovery period”
- The “normal recovery period” is defined by the surgeon and what he orders post-op
- If a surgery is not on the Inpatient Only list and there are no extenuating circumstance, then it should be performed in outpatient status and the surgeon’s usual practice pattern for the average patient having that surgery determines the normal recovery period, even if that recovery exceeds two midnights



# What Happens When the “Normal Recovery Period” Ends?

- If the normal recovery period ends and the patient requires more care within the hospital that cannot be provided at home or in the office, this is the critical decision point!
  - At this point the MD in collaboration with Care Management should ask, “based on the care provided and the anticipated care the patient still needs, will the patient have a total of two-midnights in the hospital?”

Yes= inpatient No=Observation



# Observation Tidbits

- Should always be “place in Observation” not “admit to Observation”
- Observation is a service and not a status
- CMS states clearly that Observation can be provided anywhere in the hospital.
- Observation should never be ordered before a surgery for Medicare patients






# Office of Inspector General 2016 Work Plan

- Reviews the new inpatient criteria “Two-Midnight Rule” and billing variance among hospitals
- The **OIG 2016 work plan** has a focus on short stay inpatient admissions
- Previous OIG audits, investigations and inspections have identified millions of dollars in overpayments related to short stay admissions



# Processes and Safety Nets Dartmouth-Hitchcock has Put into Place

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- Implemented workflow that admission order needing co-signature has numerous “safety nets” to ensure admission order appropriately signed
  - WQs built in Epic to catch cases that don’t cross 2 midnight for a UR and medical director review
  - Physician Advisors and Care Management leadership work with Revenue Cycle on compliance committees to identify areas of vulnerability for compliance and lost revenue

## Unsigned Order of Current Inpatients Workflow

Admitted Medicare patients missing signed admit order report run by UM staff at 10am.

At that time, UM Staff will notify the attending physician and Case Manager via email, the lack of signed order (both Case Managers, if on weekend will be notified). Subject line for email should include "Urgent Response Needed: Un-CoSigned Admission Order" and should be set up as high priority and sent with a read receipt.

On weekends/holidays, UM staff will either page or by face to face discussion attempt to get order signed/co-signed by attending.

Mon-Fri: Case Manager will either page or by face to face discussion attempt to get order signed/co-signed by attending and Case Manager will respond back to UM via email when that has occurred.

By noon, if order not signed, UM staff member will page and email the attending indicating this is a second request for a signed order. Subject line for email should include "Urgent Response Needed: Un-CoSigned Admission Order" and should be set up as high priority and sent with a read receipt.

If no response from attending by 1pm, UM staff will notify the AMD of the day by text page and by forwarding the email trail to the AMD. AMD will both page and email the attending indicating this is the 3<sup>rd</sup> request for a signed order.

At 3pm, UM staff will re-run the admitted patients missing signed admit order report and let the AMD know of any outstanding orders at that point. If order is still not signed, AMD will notify section chief/department chair lack of compliance by email and page.

If order still not signed (confirmed by AMD) by 5pm, AMD will notify Chief Medical Officer via email including email trail with attempts throughout the day.

When order signed, patient will be released automatically from missing order report.



# ED Utilization Review

- 40% of admissions come through the ED at Dartmouth-Hitchcock
- Utilize UR Case Managers in the ED to give a recommendation based on evidence-based criteria
- ED providers have admitting privileges as of 10/1/2015
- Opened 5 bed Clinical Decision Unit in Summer 2014



# Transfer Center

- 20% of admissions come through the transfer center
- Dartmouth-Hitchcock is utilizing the “quarterback” model to ensure appropriate admissions are coming in through transfer center
  - Do they meet acute care criteria?
  - Do they need tertiary care (what care do they need?)
    - Can patient be supported at referring hospital (consultation)



# UR in the OR

- Dartmouth-Hitchcock performs approximately 20,000 surgeries a year
- UR nurses review all surgeries booked with an inpatient only CPT code to ensure the admission order is placed pre-op
- Ongoing work being done to improve workflows and the Epic system to utilize technology to ensure appropriate orders are in place prior to and after surgeries and procedures.



# Key Takeaways

- The Two-Midnight Rule is here to stay
- Documentation is the strongest defense to receive payment. Ask the physicians to “think in ink”
- A strong physician advisor program is key to achieving compliant level of care determinations
- Having a strong collaborative relationship with revenue cycle partners will be essential to reduce risk



# Collaborative System of Care



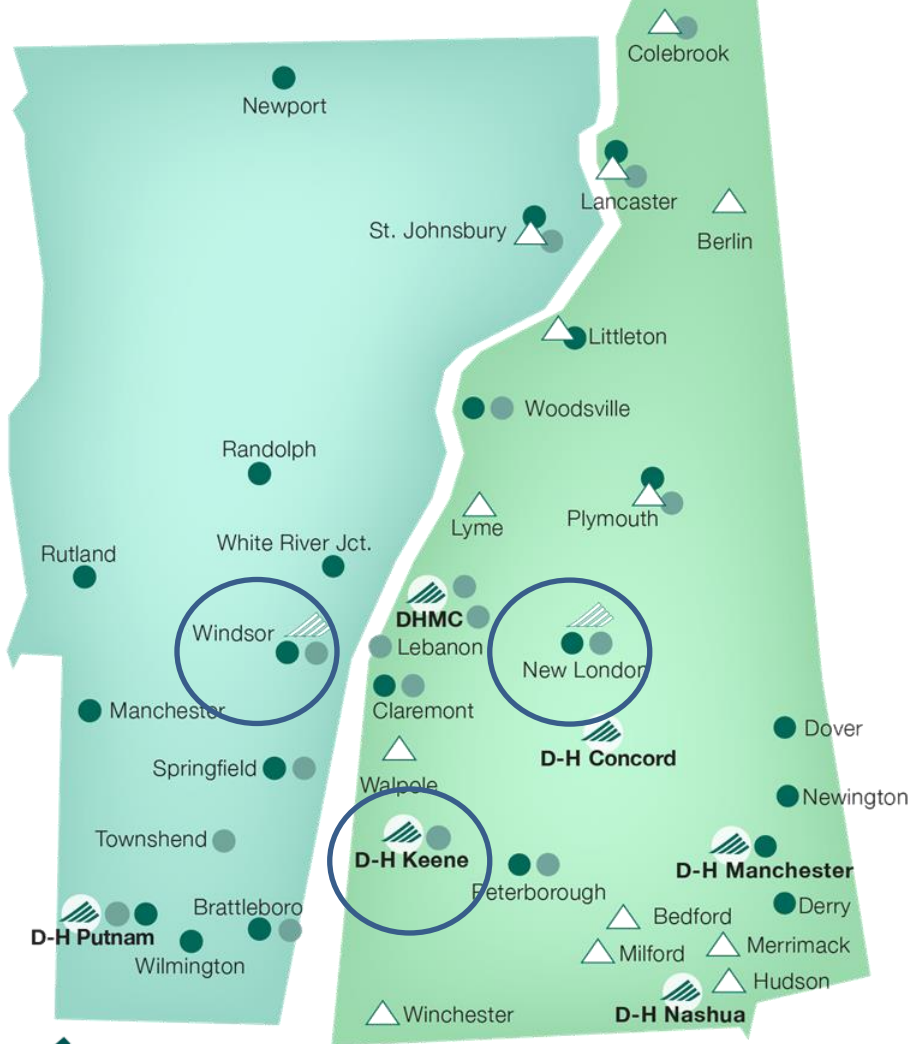
The Role of Care Management

# How Do Patients Receive Care Management at D-H Today?

- Office of Care Management-Lebanon
  - Inpatient Care Management
  - Ambulatory Care Management-CCMs
  - Inpatient Psychiatry
- Employee Wellness Program/ DH Wellness Plus
  - DHDP-employee population
- Primary Care
  - ACO-Embedded Care Coordinators
- Benevera Health-January 2016



# Dartmouth-Hitchcock Health System & Outreach



## New England Alliance for Health (NEAH) Organizations


### New Hampshire

- Alice Peck Day Hospital, **Lebanon**
- Cheshire Medical Center, **Keene**
- Cottage Hospital, **Woodsville**
- Monadnock Community Hospital, **Peterborough**
- New London Hospital, **New London**
- Upper Connecticut Valley Hospital, **Colebrook**
- Spears Memorial Hospital, **Plymouth**
- Valley Regional Hospital, **Claremont**
- VNA Hospice of VT & NH, **Lebanon**
- Weeks Medical Center, **Lancaster**
- West Central Behavioral Health, **Lebanon**

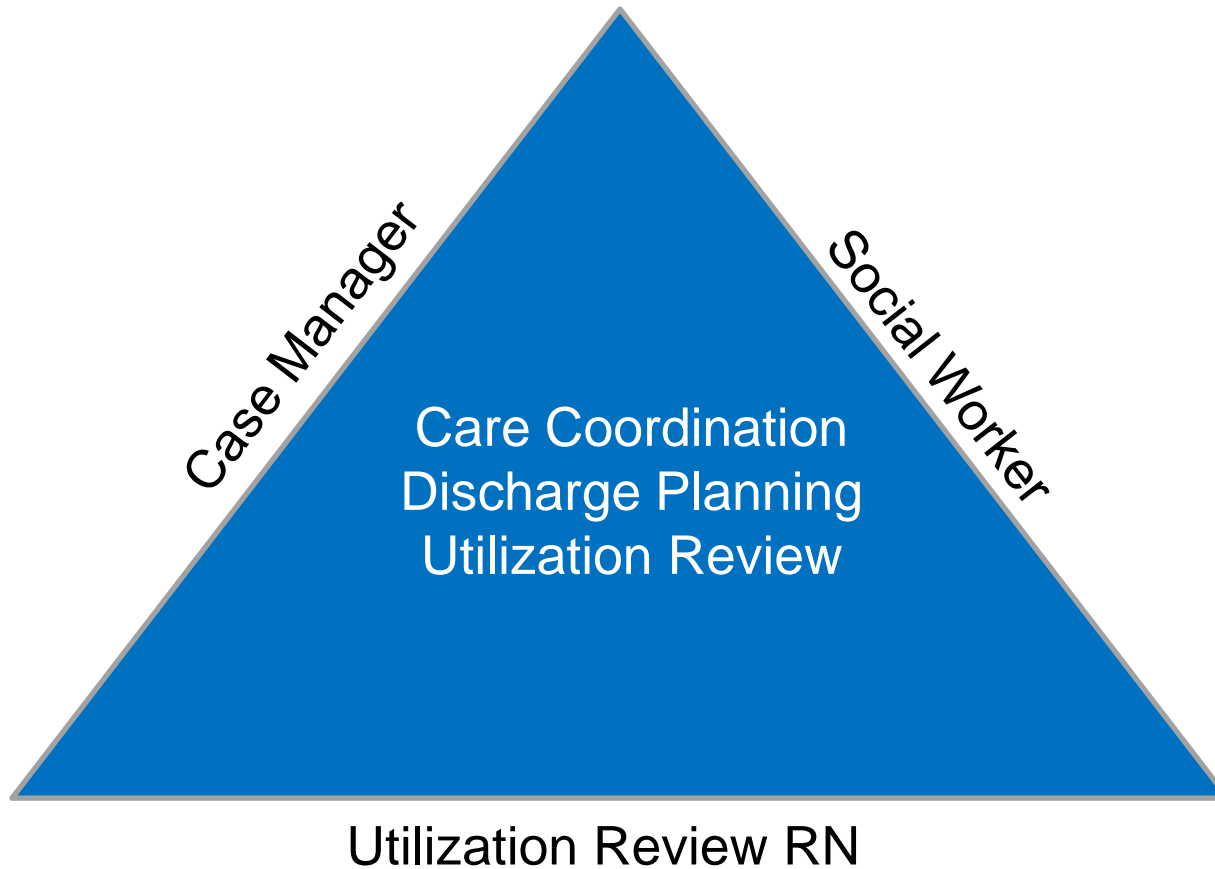
### Vermont

- Brattleboro Memorial Hospital, **Brattleboro**
- Grace Cottage Hospital, **Townshend**
- Mt. Ascutney Hospital and Health Center, **Windsor**
- Northeastern Vermont Regional Hospital, **St. Johnsbury**
- Springfield Hospital, **Springfield**
- Southwestern Vermont Medical Center, **Bennington**

-  D-H Facility
-  D-H Affiliate
-  D-H Regional Clinic
-  D-H Outreach Clinic
-  New England Alliance for Health (NEAH) Member (17)

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- Two of the four Affiliate Hospitals now have a supervisor of Care Management that reports to Director at DHMC
    - This model has already been a success!
    - Improved communication and transitions of our patients
    - Increasing appropriate transfers to increase capacity at DHMC
    - Working towards standardization of our care management processes with local autonomy

# CM Inpatient Structure Triad Model



# CM Department Structure (cont.)

- **Continuing Care Managers**--Outpatient Care Managers in specialty clinics
- **Resource Specialists**--support care management staff by managing referrals, Medicare Important Message letters, and other tasks
- **Associate Medical Directors (Physicians Advisors)**--Seven physicians in total. 5 hospitalists, 1 surgeon, 1 ED MD.



# The Role of Care Management

- Foundation of Right Patient, Right Place, Right Time, all the time
- Utilize UM nurses and associate medical directors to make sure patient status is correct and “get it right from the front door”
- Improving throughput and transitioning the patient to the next level of care with seamless communication and transition planning
- Outpatient case management and primary care coordinators to support population health and prevent readmissions





# Key Takeaways

- There is no “one size fits all” for care management structures
- Strong, aligned, and seamless care transitions are going to be necessary now and in the future
- The goal of integrated care management should be improving outcomes and quality, decreasing utilization and costs
- The patient should be at the center of everything we do!





# Accountable Care Organizations

What does that mean for Care Management?




# Care Management



*All roads lead  
to Care Management!*

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An **accountable care organization** (ACO) is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. A group of coordinated health care providers forms an ACO, which then provides care to a group of patients. The ACO may use a range of payment models (capitation, fee-for-service with asymmetric or symmetric shared savings, etc.). The ACO is accountable to the patients and the third-party payer for the quality, appropriateness and efficiency of the health care provided.



# The Shift from Volume to Value

- Health systems challenged to think differently
- Health care systems have many value-based models to choose from
  - Pay for Performance
  - Shared Savings
  - Bundled Payments
  - Shared Risk
  - Global Capitation



# Accountable Care Organizations

- Dartmouth-Hitchcock participated in the Pioneer ACO from 2011-Winter 2015
  - Value-based model designed to provide members with an improved patient care experience, improved health of populations, and a reduction in the cost of healthcare
  - DHMC is currently evaluating joining the Next Generation ACO in 2017



# Key Takeaways for Success

- Action-oriented leadership is crucial
- High performing primary care practices
- Preventative measures to keep patients from going to the ED
- Utilize data effectively and ensure its availability
- Transparency around physician performance
- Maintain patient engagement
- Seamless and robust transitions of care across the continuum

Change is the law of life and those who look only to the past or present are certain to miss the future – *John F. Kennedy*



If you always do what you've always done, you'll always get what you've always got –  
*Anonymous*

# Question and Answer Session

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## **Commission for Case Manager Certification**

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# Thank you!

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- Please fill out the survey after today's session
- Those who signed up for continuing education will receive an evaluation from the Commission.
- A recording of today's webinar and slides will be available in one week at <http://ccmcertification.org>

