Small Rural Hospital Transition (SRHT) Project Guide

A Rural Hospital Guide to Improving Care Management:

2019 Update

**NATIONAL
RURAL HEALTH
RESOURCE CENTER**

525 South Lake Avenue, Suite 320
Duluth, Minnesota 55802
(218) 727-9390 | info@ruralcenter.org | www.ruralcenter.org

Report prepared by

1685 Congress St. Suite 202

Portland, ME 04102

www.stroudwater.com

And

525 South Lake Avenue, Suite 320

Duluth, Minnesota 55802

(218) 727-9390 | info@ruralcenter.org | www.ruralcenter.org

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Preface

This guide was developed to provide rural hospital executive and management teams with generally accepted best practice concepts related to care management. We hope this guide provides opportunities to improve performance within the hospital setting and to increase knowledge and understanding of the continuing national transition from traditional fee-for-service reimbursement to a value-based, population-health-focused reimbursement environment. The guide is also designed to assist State Offices of Rural Health directors, Flex Program coordinators and Network Directors in gaining a better understanding of Care management best practices, so they may develop educational training 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 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 situation and should independently determine the correctness of any guide content before recommending to a client or implementing it on the client's behalf.

Purpose of This Guide

Inpatient care management is comprised of utilization review and discharge planning and includes processes for the patient's stay, and post-discharge. More broadly, care management may include activities related to transitions of care and ongoing proactive, longitudinal care management based on the type of organization or contract involved. Comprehensive care management is an essential, foundational capability for Accountable Care Organizations (ACOs) and other risk-bearing contracts, such as Medicare Advantage plans, to effectively manage total cost of care and to support and facilitate delivery of timely, appropriate care and services to their members. The purpose of this guide is to present current best practices in care management and to provide an understanding of the care management capabilities and competencies an organization must develop or procure in order to transition successfully from fee-for-service (FFS) reimbursement to value-based payment.

In particular, the objective is to increase rural hospital leadership 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 rural health partners may also benefit from this guide, as it assists them to ask the right questions when meeting with hospital leadership.

The Population Health Transition Framework

The strategic framework shown below (Figure 1) is designed to assist organizations in transitioning from a payment system dominated by the fee-for-service payment model to one dominated by value-based payment models.

Figure 1. Payment and Delivery System Reform Transition Framework

Payment and Delivery System Reform Transition Framework
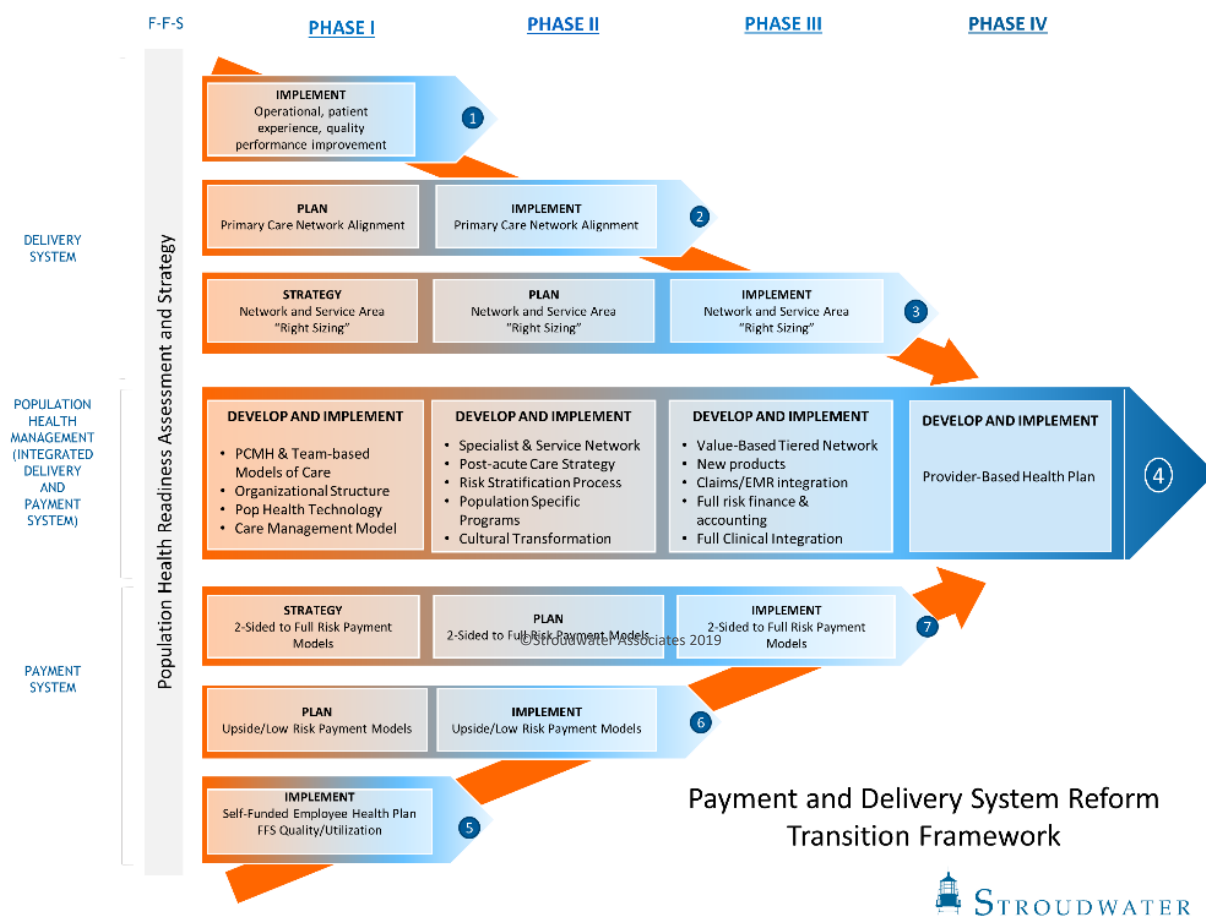
- *The Delivery System portion of the framework* addresses the imperative to transform the current "sick care" model to a "health and wellness care" model, as the organization moves from FFS to value-based payment.
- *The Payment System* section of the framework addresses the national imperative to proactively transition reimbursement from FFS to value-based payment.
- *The Population Health Management* row is the "backbone" and represents all the elements (infrastructure, processes, resources, programs) required to create an integrated delivery/payment system able to support and succeed in a value-based payment environment.

Strategic imperatives drive the initiatives that must be designed and implemented to make the transition.

- Each initiative is developed in phases that correspond to the evolution of the payment models (Phase I, Phase II, Phase III, Phase IV)
- Work on each initiative must begin in advance, so that the organization is ready to implement when required
- Hospitals and providers must *strategize, plan, and implement, as they move through each phase of the* framework

This care management guide will focus and refer to the Population Health Management component of this framework and address what hospitals and providers should be planning, developing, and implementing regarding their care management model.

Care Management Process Overview

Care management is crucial in guiding and educating patients with complex health care needs through a complex health care delivery system. Successfully doing so unleashes significant potential to improve overall population health and to reduce total cost of care. The Center for Health Care

Strategies has developed a [Care Management Framework](#)[1] that outlines and defines the key components of a comprehensive care management program and provides examples of tools and strategies that can be utilized to effectively meet the needs of patients with complex and special needs.

Definitions

What Is Care Management?

Care management programs apply systems, science, incentives and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.[2]

What Is Case Management?

The Case Management Society of America (CMSA) defines Case Management 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 patient safety, quality of care, and cost-effective outcomes.[3]

The basic concept of case management involves the timely coordination of quality services to address a client's specific needs in a cost-effective and safe manner, in order to promote optimal outcomes. This can occur in a single health care setting or during the client's transitions of care throughout the care continuum. The professional case manager serves as an important

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[1] "Care Management Definition and Framework." Center for Health Care Strategies. December 28, 2016. Accessed July 01, 2019. http://www.chcs.org/resource/care-management-definition-and-framework/.

[2] "Care Management Definition and Framework."

[3] "CMSA's Standards of Practice for Case Management, 2016." CMSA Home - Case Management Society of America. Accessed July 01, 2019. http://solutions.cmsa.org/acton/media/10442/standards-of-practice-for-case-management.

facilitator among the client, family or family caregiver, the interprofessional health care team, the payer, and the community. [4]

What Is Care Coordination?

Care Coordination involves the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care (AHRQ, 2007). A "function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time" (NQF, 2010, p. 1).[5]

Hospital-Based Care Management

The fundamental 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 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
- Core measure management
- Care transition navigation and/or management
- Clinical Documentation Improvement (CDI)

The care manager is the liaison between the patient/family, providers, staff and community resources. The success of care management depends on effective communication with the patient, physicians (inpatient and clinics), the family/significant other, nursing, therapists, registration staff, the business office director, the health information management (HIM) director

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[4] "CMSA's Standards of Practice for Case Management, 2016." P. 11
[5] "CMSA's Standards of Practice for Case Management, 2016." P. 32

and biller/coders, swing bed referring sources, other hospital departments (emergency department/lab/radiology, respiratory therapy), payors and community resources.

Crucial to an effective and efficient care management program is having organized routines and processes in place as well as maintaining thorough records. Ideally, the roles and responsibilities of care management are assigned to a clinician due to their background and versatility with any of the duties, as well as their experiences working together with physicians. Most rural hospitals have one care manager whose role includes the UR and discharge planning responsibilities and who acts as the swing bed coordinator. Some facilities have an UR nurse and a discharge planner (a nurse or social worker) who 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.

Small rural hospitals with very low inpatient census may 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 hospital (house) supervisors for evenings and weekends, these staff members should be trained in utilization review, which allows for an in-house resource available 24 hours a day, seven days a week, enhancing the typical Monday through Friday care management.

More recently, CDI staff are frequently being added to the care management team. CDI staff are providing increased education/training for their UR staff, given the importance of thorough and accurate provider documentation. The CDI staff positions often report to health information management (HIM) leader, the chief financial officer (CFO) or the chief executive officer (CEO). In small hospitals, the care manager may be the one trained in clinical documentation improvement since they are already reviewing charts and physician documentation daily to accomplish their UR and discharge planning roles.

- Improving the accuracy and completeness of clinical documentation can reduce compliance risks, minimize a health care facility's vulnerability during external audits, and provide insight into quality of care and patient safety issues
- Strong clinical documentation that appropriately captures the patient's medical status including co-morbidities, along with efficient coding, can improve revenue per discharge
- Additional information on Clinical Documentation Improvement (CDI) is available online at:
  - http://www.ahima.org/topics/cdi
  - https://en.wikipedia.org/wiki/Clinical_documentation_improvement

A question often asked by 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 per diem payment for each swing bed patient. MDS assessments are not required in CAHs, hence are less demanding for care management staff hours.[6, 7]

In conclusion, administration should consider the following to determine staffing needs both for number of adequate staff and how staffing is impacted based on the time of day:

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[6]"MDS 3.0 for Nursing Homes and Swing Bed Providers." CMS.gov Centers for Medicare & Medicaid Services. March 06, 2015. Accessed July 01, 2019. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30.html.

[7] "Skilled Nursing Facility PPS." CMS.gov Centers for Medicare & Medicaid Services. April 19, 2019. Accessed July 01, 2019. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html.

- What is the average daily census (ADC)?
- What times of the day do providers round?
- Is there a hospitalist model or are there multiple physicians admitting and rounding?
- What are the busiest admission days and times of the day?
- Does the facility employ house supervisors?
- Does the facility experience enough volume to justify weekend coverage or can care management be covered with staff members working from home?
- What is facility backup system to ensure UR, discharge planning and swing bed coordination are covered on sick days and vacations?

What are the current responsibilities of the care management team?

- Utilization review
- Discharge planning
- Facilitate referral to community resources
- Social work availability or acting as social work designee frequently needed in emergency department
- Core measure management
- Involvement in post-discharge follow-up
- Accountable to grow the swing bed business with external referrals

Performance improvement opportunity recommendations frequently seen in care management are as follows:

- Ensure adequate training for the role/responsibilities
- Create a collaborative care management presence by pulling all staff together involved under the department/leadership to alleviate silos
- Ensure UR processes are robust and thorough, especially for Medicare beneficiaries
- Educate all staff on the importance of level of care determination regardless of CAH or PPS
- Complete retrospective utilization review for patients admitted and discharged when there is no UR staffing by educating additional staff
- Prompt discharge planning and thorough documentation of discharge planning activities
- Educate all staff regarding discharge process to ensure discharges are standardized regardless of who is completing the discharge

- Build positive collaborative relationships between emergency and inpatient physicians
- Educate all providers on care management and UR roles and responsibilities
- Ensure appropriate level of care determination is completed at time of placement to eliminate changing from IP to OBS or OBS to IP
- Standardize care management tasks to clarify roles and responsibilities directly related to care management
- Provide education regarding the "2 Midnight (MN) Rule" for inpatient versus observation services and the 96-hour rule for CAH designation
- Ensure UR process is covered for after hours, weekends, and holidays
- Design and implement an effective post-discharge follow-up process
- Provide education regarding appropriate forms required for beneficiary
- Develop ongoing data tracking and trending
- Provide education regarding data analysis for process improvement purposes
- Standardize UR meetings and clarify care management responsibilities

Discharge Planning Process

CMS Requirements

CENTER FOR MEDICARE AND MEDICAID (CMS) THE CONDITION FOR PARTICIPATION (COP) §482.43: 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."

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 graphic below):

- Screening all inpatients to determine which are at risk of adverse health consequences post-discharge without appropriate 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 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 (Figure 2) are implemented consistently."

Figure 2: Discharge Planning Process
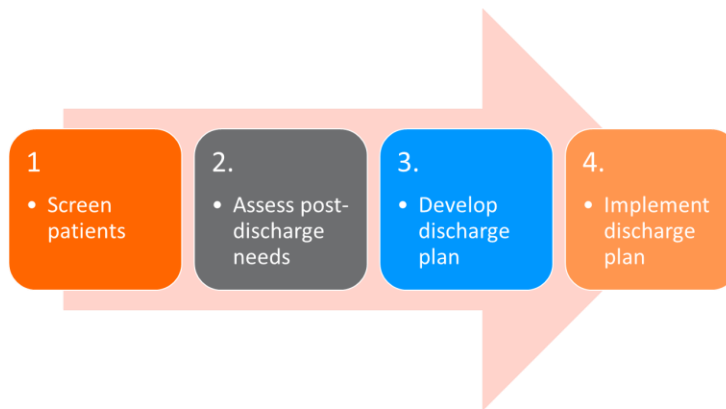
Although not required, CMS recommends providing a discharge planning tool to patients, family members or significant others to aid in reinforcing the discharge plan. CMS notes that using the tool may encourage patients' participation in the development of their discharge plan as well as providing them with a guide to help with a successful transition from the hospital.

Examples of available tools include:

- Medicare's "Your Discharge Planning Checklist,"
- Agency for Healthcare, Research and Quality's (AHRQ) "Taking Care of Myself: A Guide for When I Leave the Hospital,"
- Consumers Advancing Patient Safety (CAPS) "Taking Charge of Your Healthcare: Your Path to Being an Empowered Patient Toolkit"

Discharge Planner Responsibilities

Best practice describes the discharge planner's responsibilities as including but not limited to the following:

- Review nursing discharge planning documentation incorporated in the nursing admission assessments within 24 hours if possible, to begin the ongoing discharge planning process
- In small 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
- Facilitate daily interdisciplinary huddles on acute care patients and weekly for swing bed patients to ensure the team has the same discharge plan
- Consider rounding with the physicians, which often proves to be highly beneficial. If more than one provider rounds at the same time, someone else may also be assigned to round, but then the various discharge planners should meet to review and discuss outcomes of the rounding.
- Visit with the more complicated patients and those who will potentially need a post-acute care program or service first
- Call families of those not available at the hospital as needed and invite families to rounding and bedside report. Document all visits and calls to family in EHR
- Address Advance Directives on admission
- 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
- 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. This 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 vital to identify what is done well and any opportunities for improvement.

Refer to Appendix C for the Discharge Planning metrics.

Refer to Appendix D for a self-assessment regarding Discharge Planning processes.

Utilization Management

The term "Utilization Management" (UM) is often used interchangeably with "Utilization Review" (UR). There is no single accepted definition for UM in the literature, although the key elements of *medical necessity* and *appropriateness of care* are common across multiple definitions. URAC defines UM as "the evaluation of medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health plan benefits, sometimes called UR."[8]

The Institute of Medicine Committee on Utilization Management by Third Parties recognizes UM as a "set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing patient care decision-making through case by case assessments of the appropriateness of care…"[9]

UM/UR involves the review of care based on a determination of medical necessity. A primary purpose of Utilization Review is to ensure that the patient is being admitted or initially placed in the correct level of care based on the patient's needs and that ongoing care/length of stay are medically appropriate, in accordance with the Payer's relevant regulations/requirements for the services rendered and the relevant standard treatment guidelines. More broadly, the APTA Board of Directors states that "UR is a process that

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[8] Gardner, Kelly. "What Is Utilization Management?" APTA. Accessed July 01, 2019. https://www.apta.org/WhatIsUM/. Updated 4/26/2017
[9] "What Is Utilization Management?"

has two primary purposes: to improve the quality of services (and patient outcomes) and to ensure the efficient expenditure of money."[10]

UR best practice recommendations presented here are intended for small rural hospitals, including those facilities that are minimally staffed with only one UR staff person:

- Review demographic information on face sheets of all new admissions
- Determine where to start based on the new admissions payers' requirements (Medicare, Medicaid, commercial payers, payers 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:
  - o Admit to acute or place in observation
  - o OP service in an IP bed
  - o Extended OP in an IP bed
- Ensure the pre-certification notification is completed and documented for payers requiring it
- Determine the certification requirements for payers based on priority (prioritize based on when the information must be reported to the payer)
- Review provider documentation (emergency department medical record, history and physical exam, progress notes, orders and test results thus far)
- Call payer case managers as necessary or use their required electronic form or fax result of review based on payer'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 Midnight based on presenting medical issues, co-morbidities, and risk if discharged (signed certification is no longer required)
- Medicare reviews include the following:

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[10] "What Is Utilization Management?"

- Ensure that the Medicare patients have signed the *Important Medicare Message (IMM)* letter on admission and provide letter as needed
    - https://www.cms.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices.html
- For observation lasting greater than one midnight but less than two when counting midnights spent in outpatient by the time of UR, options are:
    - Discharge if stable (continue work-up on an outpatient 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 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 any misunderstanding by 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)
    - Request Medical Director/Advisor review, if applicable, and document accordingly
- 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 by 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.

- o For patients placed in observation, the UR manager should:
    - ▪ Confer with the day charge nurse before leaving to discuss patient status, etc.
    - ▪ Communicate with the primary care physician (PCP) before leaving for the day and discuss the next step (discharge before midnight or be admitted), if not yet determined
    - ▪ Share discussion with the house supervisor or the evening charge nurse to ensure that all parties agree regarding patient disposition plans
- Document UR findings, particularly 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 Patient's Medical Record daily to ensure that patient continues to require inpatient stay level of care; discuss issues with the provider and manage the length of stay. Using the InterQual or Milliman Clinical Guidelines 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 in which the patient was placed
    - o For instance, facility cannot knowingly bill for observation or inpatient if the patient was a "social admit"
    - o 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 CMS website for guidance regarding the IMM letter:
            - https://www.cms.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices.html
- Track and report UR data to administration and the medical staff
- Participate in revenue cycle meetings

Utilization review may entail a review of medical records in comparison with standard clinical guidelines such as InterQual or Milliman. Utilization Review considers whether the physicians' documentation supports medical necessity, as well as diagnostic test results and treatments provided.

THREE TYPES OF UTILIZATION MANAGEMENT

- *Prospective Review, also referred to as Prior Authorization or Pre-Certification,* refers to requests for approval of future planned medical care and services in order to reduce or eliminate services determined to be unnecessary.

- *Concurrent Reviews* are performed during treatment or an episode of care, particularly for inpatient hospital and Skilled Nursing Facility stays. Concurrent review also addresses requests for approval of additional treatments or procedures during an episode of care. Expected length of stay is generally monitored as a component of concurrent review.

- *Retrospective Reviews,* performed after health care services have been delivered, assess appropriateness of the services, setting, and timing of care in accordance with specified criteria. Such reviews often pertain to payment and may result in claims denials.

UM/UR philosophy is to provide the appropriate care at the appropriate time in the appropriate setting for the appropriate length of time for optimal outcomes based on resources. This should apply to both hospital and payer UR.

UR nurses work in hospitals, nursing homes and clinical settings where they manage patient utilization through daily case reviews. 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 health 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 initially assigned to the patient. Ideally, UR staff have an effective working 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 stay, 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 does not meet criteria for any of those levels.

Some hospitals now cover UR seven days a week (with weekends/ evenings from home contingent on access to the 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. Utilization review/utilization management can include concurrent review of documentation to support ICD-10 documentation requirements.

Utilization Review Data Tracking

As in any department, data tracking is used to manage resources. Tracking utilization continuously provides leadership and staff a finger on the pulse of business. All other data is used to determine opportunities for improvement. Data should be tracked and reported monthly. If there are obvious issues, data tracking can help identify root causes.

- 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 management improvements and to prevent costly denials.

- See Appendix B for a self-assessment regarding UR management practice and processes.

Transitions of Care

Care Coordination/Transitions

The term "care transitions" refers to the movement of patients between health care 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 a chronic or acute illness.

Hospitals should see care transitions programs as a priority because of the following:

- CMS expects hospitals to focus on preventing readmissions
- 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

There are multiple issues that may highlight the need for the organization to focus on improving the transition of care such as:

- Last minute or poor discharge instructions from the hospital creates further confusion
- Patients might be referred to as "non-compliant" versus the need for staff to take the time to assess the individual situation including social determinants and provide appropriate resources
- Medication errors involving misunderstanding of instructions, medication adherence, drug-drug interactions and duplicate prescriptions may occur
- Patients may stop medication due to perceived side effects or finances
- 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 pre-arranged 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 for what 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, Emergency Medical System, Area Agency on Aging etc.) and they are providing 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 materials
- Using of "Teach Back" method for patient/family teaching
- Using a Discharge Timeout
- Creating and implementing standardized processes for medication reconciliation
- Ensuring PCP follow-up appointment is made before the patient leaves the hospital and verifying that transportation is available
- Implementing follow-up calls 24-48 hours post-discharge

What Is Community Care Coordination?

At the Rural Care Coordination and Population Health Summit held in May of 2019, the participants modified a Community Care Coordination definition provided by Stratis Health and adopted the following definition. Community Care Coordination is "a collaboration among health care professionals, clinics, hospitals, specialists, pharmacies, mental health, community services, and other resources working together to provide person-centered coordinated care."[11]

Community Care Coordinator

To provide seamless transitions of care, care coordinators are highly effective when working alongside the health care team. Care coordinators assume

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[11] Rural Care Coordination and Population Health Management Summit: Summit Findings July 24, 2019; prepared by Rural Health Association of Tennessee and National Rural Health Resource Center.

many roles such as educators, navigators, and care management, and can assist in numerous areas including but not limited to[12]:

- Appointment scheduling and follow-up
- Health education
- Patient navigation
- Care management
- Medication management
- Care transition support
- Referrals
- Self-management support
- Culturally competent and linguistically appropriate care
- Transportation assistance
- Translation services
- Community outreach
- Program eligibility and enrollment assistance
- Linkages to other community-based or social services

Please find additional information concerning Care Coordination Models and program descriptions.

Joint Health Partners

Many hospitals have created partnerships with local entities also involved in caring for patients within the community, thus establishing a venue for communication and sharing of community resources. These partners can include home health, nursing home, hospice, EMS, pharmacy, clinic, clergy, wellness center, Public Health, schools, and others as applicable.

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[12] "Care Coordinator Model - Rural Care Coordination Toolkit." Care Coordinator Model - Rural Care Coordination Toolkit. Accessed July 01, 2019. https://www.ruralhealthinfo.org/toolkits/care-coordination/2/care-coordinator-model.

Post-Discharge Follow-up

Best practice recommendation is for post-discharge follow-up calls to occur 24-48 hours post discharge and then weekly for 30 days. In addition, at a minimum weekly follow-up calls should take place for patients 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; some hospitals create extra support by involving a social worker. Findings from the follow-up calls are shared with their providers. Some hospitals have added a nurse home visit for more concerning patients within a few days post discharge and continuing weekly (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). Alternatively, RHCs and FQHCs can furnish visiting nurse services to homebound patients where CMS certifies that there is a shortage of home health agencies and certain criteria are met[13].

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 signs and symptoms specific to their diagnosis, visits to each health care setting, dates they were treated, reason for treatment, any medications, 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 and providing patient/family education and provision of tools.

Other hospitals 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 that assign health or transition coaches to patients.

An article by the California Healthcare Foundation titled "Navigating Care Transition in California – Two Models for Change" presents the Four Elements of the Coleman Care Transitions Interventions: (1) Medication Self-

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[13] United States, Centers for Medicare and Medicaid Services Medicare Learning Network, Department of Health and Human Services. (2019). Rural Health Clinic (ICN MLN006398).

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.

ACO Care Management (For Hospitals/Providers Participating in an ACO or Other Value-Based Contract)

Definitions

Accountable Care Organization (ACO)

- ACOs are groups of doctors, hospitals and other health care providers who come together voluntarily to offer coordinated high-quality care to their Medicare patients.[14] In general terms, an ACO is responsible for the cost and care of any defined population. Examples of ACOs include Medicare Shared Savings Program (MSSP), Next Generation, Primary Care First, Medicaid ACOs, and commercial ACOs.

ACO Members

- All value-based contracts must identify the population for which the provider organization is accountable and identify the method for attributing or assigning the population/members defined. CMS ACO members are defined as the ACO's attributed lives. "The ACO model requires that each ACO have a defined patient population for which the ACO will be held accountable for both total cost of care and quality performance. There are two major methods of defining, or attributing, patient populations to ACOs: the prospective method and the performance year method."[15]

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[14] "Accountable Care Organizations (ACOs)." CMS.gov Centers for Medicare & Medicaid Services. March 08, 2019. Accessed July 01, 2019.
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/.
[15] Health Aff (Millwood). 2013 March; 32(3): 587–595. doi:10.1377/hlthaff.2012.0489.

Risk Stratification

- The process of categorizing individuals and populations according to their likelihood of experiencing adverse outcomes, e.g., high risk for hospitalization.[16]

Population Health

- Population health is defined as **the health outcomes of a group of individuals, including the distribution of such outcomes within the group.** These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group.[17]

Population Health Management

- Population Health Management proactively identifies and addresses the needs of populations of people rather than focusing episodically on individual patients only when they seek or access health care services.

Risk-Stratification of the Population

Hospitals and providers participating in ACOs must develop or procure the capability to risk-stratify their patient population, including selection of risk stratification criteria and a methodology to classify members into identified risk categories—for example, low-moderate/rising-risk/high-risk categories. The selected risk stratification criteria should reflect the population served by the ACO. Generally, risk criteria include inpatient hospital and ED cost and utilization data, pharmacy cost and utilization data, pertinent diagnosis and clinical conditions data, and increasingly, key social determinants of health (SDOH) data for that population. Both claims data and EHR data are important data sources in the risk stratification process, as available.

The identified risk categories can then be correlated with defined levels of intensity of Care management services offered to the respective risk levels.

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[16] "CMSA's Standards of Practice for Case Management, 2016." P. 36

[17] "Populations, Population Health, and the Evolution of Population Management: Making Sense of the Terminology in US Health Care Today." Institute for Healthcare Improvement. Accessed July 01, 2019. http://www.ihi.org/communities/blogs/population-health-population-management-terminology-in-us-health-care.

For example, low risk members may be offered health and wellness programs; encouraged to seek appropriate preventive care and services via mass communications and member outreach campaigns, such as promoting a "Diabetic Eye Exam Day"; and provided access to health education resources to maintain wellness and prevent disease onset or disease progression.

Rising-risk and high-risk members may be offered care management and complex care management services and programs, respectively, with defined, tiered levels of frequency of care management outreach and follow-up based on the member's risk level and expected intensity of care needs.

ACOs may also procure or develop and implement *predictive modeling* to identify members with expected future risk of significant medical costs and high level of clinical risk.[18] The Center for Health Care Strategies, Inc. (CHCS) describes predictive models as "algorithm-driven models which use multiple inputs to predict high-risk opportunities for care management".[19]

Identification of Members Needing Ongoing Care Management

Individuals with complex medical, behavioral health/substance use disorder and/or social determinants of health needs may benefit from ongoing, longitudinal care management.

Care Needs Screening tools and Comprehensive Assessment tools, analysis of patient/member health care utilization and cost data, and patient/member risk stratification scores are utilized to identify individuals who would potentially benefit from ongoing care management services and support. (See Appendix F for a sample Comprehensive Assessment Tool and sample health screening tools.)

Population Health Management

Developing the infrastructure and capabilities to focus on population health management is essential in a risk-based reimbursement environment, particularly for ACOs participating in two-sided risk arrangements. Registries are an important tool to enable the identification, monitoring, and tracking of

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[18] "Trends in Case Management Acuity Determination"; Care Management: April/May 2016.
[19] "Care Management Definition and Framework."

sub-populations of patients within and across practices to identify and proactively address gaps in care, support chronic disease management, and promote timely preventive health screenings and services.

Proactive outreach to identified sub-populations can be done via targeted mailings, email blasts, or other communication methods. Examples include addressing due or past due diabetes care for all know diabetics within a provider's panel of patients across multiple physician practices or across the hospital's population or sending out mammogram and colonoscopy reminders based on member age and gender criteria, per evidence-based clinical practice guidelines adopted by the organization.

Roles and Responsibilities of ACO Care Management Staff

Developing, implementing, and/or managing a comprehensive care management program are essential activities for any ACO, including Medicare ACOs, Medicaid ACOs, or commercial payer ACOs. According to the Agency for Healthcare Research and Quality (AHRQ), care management has emerged as a leading strategy to manage the health of populations. "Care management is organized around the principle that appropriate interventions for individuals within a given population will reduce health risks and decrease the cost of care."[20]

ACO CARE MANAGEMENT PROGRAM DEVELOPMENT AND IMPLEMENTATION

As highlighted in the Population Health Management component of Figure 1. *Payment and Delivery System Reform Transition Framework*, during implementation, a newly formed ACO must make several key strategic and tactical decisions regarding its care management Program, including:

Phase I:

- "Buy versus build" decisions for its overall care management program, such as whether to contract with an external care management company or other entity to perform all care management functions on

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[20] Care Management: Implications for Medical Practice, Health Policy, and Health Services Research. Content last reviewed August 2018. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/caremanagement/index.html

behalf of the ACO or to hire/deploy internal resources to develop and implement the ACO's own care management program

- Determination of the ACO Care Management Model, including:
  - Deciding whether to create a centralized care management staff versus embedding care managers within individual Primary Care practices or Primary Care clinics
  - Telephonic care management services versus face-to-face services or a combination
  - Future integration of home telemonitoring services
- Determination of care management program goals and objectives and key performance metrics. For example, offering time-limited versus open-ended care management services to selected ACO members versus all ACO members.
- Determination of the care management organizational structure and composition of care management staff, such as RN Care Managers, Behavioral Health Clinicians, Community Health Workers or Patient Navigators, dietitians, pharmacists, administrative support personnel, based on the selected Care management Model
- Selection of a care management electronic platform to house and manage care management-related assignments and documentation

Phase II:

- As discussed previously, the ACO should select and implement risk stratification criteria and a methodology to classify members into defined risk categories such as low-moderate/rising-risk/high-risk categories, according to their likelihood of experiencing adverse outcomes.[21] Each risk category can then be correlated with a defined level of intensity of care management services to be offered to those members.
- Development and implementation of targeted care management and disease management programs and interventions for members/sub-populations, based on the ACO's population data and identified top priorities for action
- Other critical Phase I-II Transition Framework activities include:
  - Analysis of available membership and claims data to develop an overall profile of the membership—demographics, top clinical conditions/diagnoses, risk scores, SDOH data, cost and utilization

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[21] Case Management Society of America, *Standards of Practice for Case Management*. *Section X Glossary*. Little Rock, AK. Revised 2016; accessed at cmsa.org; page 36.

history (inpatient admissions and readmissions, ED utilization, PCP visit utilization, pharmacy data)

- o Establishment of a methodology/process to assign ACO members to care management resources, based on the selected care management model and relevant population data

Phase III:

- Behavioral health, home and community-based services, post-acute care, palliative care and complementary therapy integrations
- Telemedicine integration

KEY ACO CARE MANAGEMENT RESPONSIBILITIES

Rural hospitals and clinics are often part of a larger healthcare system which may be participating in an ACO arrangement or the rural hospital may participate in a multi-hospital ACO. Thus, roles and responsibilities to perform Care Management functions and services at the local level will be based on the Care Management model selected by the ACO entity, as further discussed above under the Phase I section.

Unless the ACO has contracted with an outside party to perform care management functions on its behalf, ACO care management staff will typically have primary responsibility to perform the following core components of the care management process under the direction of identified ACO leadership, including regular ongoing access to a physician leader for medical direction and clinical oversight.

1. *Identify and engage ACO members* in active care management via incoming member referrals to care management and via proactive outreach to identified high- and rising-risk members with modifiable risk
   - Not all identified high risk members need or will benefit from care management services. For example, individuals who are at the end of life receiving palliative care or hospice care; individuals on very high cost medications but who do not have other risk factors indicating a need for care management services; or individuals who have had a major time-limited illness or injury in the past but have subsequently recovered and no longer are experiencing high utilization or costs of care

2. Perform a *Comprehensive Assessment* addressing members' medical/surgical history and current medical, behavioral health, and substance use status and needs, social determinants of health, functional status, level of cognitive functioning, family/caregiver support, educational background, language and cultural considerations
   - Implement and utilize standardized screening and comprehensive assessment tools. (See **Appendix F** for sample patient/member screening and assessment tools.)
   - Utilize effective communication skills including active listening, motivational interviewing, and use of open-ended questions[22](See **Appendix F** for suggested resources regarding motivational interviewing.)
3. Prepare a member-centric *Case Management Plan of Care* in collaboration with member and their family/caregiver(s) and other members of the interdisciplinary care team. The Plan of Care should include member-focused goals and agreed upon interventions, action plans, and resources necessary to address the member's identified health care and related social service needs. (See **Appendix F** for sample care plan templates.)
4. Monitor and periodically *follow up with members receiving care management services*, review progress toward agreed upon goals and action plans, assist to identify and address barriers, and *update Care Management Plans of Care,* as indicated
5. Work with members and their family/caregiver(s) to determine appropriate timing to *complete care management* services in accordance with the organization's established case closure criteria and processes
6. Assist with/perform *care coordination* and facilitate *transitions of care,* when members access care across multiple providers and/or across the ACO care continuum
   - Clearly define care management roles and responsibilities across the ACO
   - Develop and implement standardized processes, workflows, and tools across the ACO entity to maximize efficient, timely coordination of care and transitions of care and to minimize gaps or duplication of services

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[22] Case Management Society of America. *Standards of Practice for Case Management; Section VII. Components of the Case Management Process.* Little Rock, AK. Revised 2016; accessed at cmsa.org

- *Communicate and collaborate* with inpatient and ED Case Managers, PCP and specialty practices, post-acute care, and home and community-based service providers and agencies to help ensure member is accessing the right care at right time in most appropriate setting

ACO Utilization Management

- Total Cost of Care is a critical metric for organizations participating in risk arrangements, particularly two-sided risk arrangements. The ACO/Value-based Care entity must periodically analyze and review cost and utilization data across the ACO/Value-based Contract entity by service type, by diagnosis codes, by provider, and by provider type to identify patterns and trends and opportunities to reduce costs and utilization.

- Inpatient admission and readmission rates, ED visit rates, and total costs for pharmacy are critical ACO performance metrics

- The ACO entity must implement standardized processes and procedures to collect, analyze, and report cost, quality, and utilization data on a regular, periodic basis, including timely sharing of results with ACO providers and staff

- Many risk arrangements include quality performance thresholds which must be met for the ACO to receive quality bonuses or achieve shared savings. It is essential for providers and staff to be aware of the ACO's quality metrics and performance targets and to align clinical operations with achievement of the organization's quality targets.

Roles and Responsibilities of Managed Care Organization Staff or Others

A Managed Care Organization (MCO) has been defined as "A health care delivery system consisting of affiliated and/or owned hospitals, physicians and others which provide a wide range of coordinated health services; an umbrella term for health plans that provide health care in return for a predetermined monthly fee and coordinate care through a defined network of physicians and hospitals. Examples Health Maintenance Organizations and Point Of Service plans."[23]

MCOs generally perform the same/similar member-level and population-based care management programs and services as outlined previously for ACOs. In many cases, the MCO delegates selected care management functions to their partner ACO(s) but may retain responsibility for complex care management for specific sub-populations of their membership, such as transplant patients or individuals with advanced cancers.

In addition, an MCO must procure or have capabilities to receive and process claims for services delivered to their members and must have capabilities to collect and report cost, utilization, and quality data.

MCOs also must meet state and federal regulatory requirements related to member marketing and enrollment/disenrollment processes; develop and manage or contract with a provider network and ensure compliance with required access to care standards; maintain processes to handle member appeals and grievances; implement or procure Member Services and after-hours advice and triage arrangements; and perform or procure comprehensive utilization management functions. Managed Care 101: Understanding the Basics and Opportunities for Partnership provides a general overview of managed care and additional background information.

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[23] managed care organization. (n.d.) McGraw-Hill Concise Dictionary of Modern Medicine. (2002). Retrieved July 30 2019 from https://medical-dictionary.thefreedictionary.com/managed+care+organization

Medicare's Care Management Programs

Chronic Care Management[24]

Chronic Care Management (CCM) services are designed to address the complex needs of Medicare beneficiaries suffering from multiple chronic conditions. CCM allows health care professionals to be reimbursed for the time and resources used to manage Medicare patients' health between face-to-face appointments. CCM can be furnished to Medicare patients with two or more chronic conditions who are at risk of death, acute exacerbation/decompensation, or functional decline.

CCM services include:

- Conducting an initial face-to-face visit
- Utilizing EHR to record patient health information
- Development of a comprehensive care plan
- Access to care and care continuity (24/7)
- Comprehensive Care Management
- Transitional Care Management

In addition to physician practices, CCM services can be provided by <u>Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs)</u>, including Provider-based RHCs and CAHs.

The following health care professionals can bill for CCM services:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Certified Nurse Midwives
- Clinical Nurse Specialists

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[24] United States. Centers for Medicare and Medicaid Services Medicare Learning Network. Department of Health and Human Services. *Chronic Care Management Services*. Vol. ICN 909188. December 2016.

Only one practitioner/facility per patient may be paid for CCM services for a given calendar month. Services may be furnished by the billing health care professional as well as clinical staff that meet Medicare's "incident to" rule.

Medicare allows:

- At least 20 minutes of clinical staff time directed by a physician or other qualified health care professional is required in order to bill Medicare for the service **(CPT 99490)**
- Moderate or complex medical care, up to 60 minutes of clinical staff time must be recorded for billing purposes **(CPT 99487).** Note that CCM services are subject to the usual Medicare Part B cost sharing requirement.

Transitional Care Management[25]

Transitional Care Management (TCM) services are designed to prevent hospital readmissions by providing seamless care when a patient is discharged from an inpatient facility (hospital) to community-based care (clinic).

Providers may conduct the following TCM components beginning at the day of discharge up to 30 days:

- Interactive contact within two business days of discharge (phone, email, face-to-face)
- Certain non-face-to-face services (review discharge information, establish referrals, interact with other health care professionals)
- Face-to-face visit within either 7-14 calendar days of discharge

These health care professionals may furnish TCM services:

- Physicians (any specialty)
- Physician Assistants
- Nurse Practitioners
- Certified Nurse Midwives
- Clinical Nurse Specialists

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[25] United States. Centers for Medicare and Medicaid Services Medicare Learning Network. Department of Health and Human Services. *Transitional Care Management Services*. Vol. ICN 908628. January 2019.

Hospitals may provide TCM services beginning the day of the patient's discharge from one of these inpatient hospital settings:

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long-Term Care Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a Community Mental Health Center

After inpatient discharge, the patient must return to their community setting:

- Home
- Domiciliary
- Rest home
- Assisted living facility

Medicare allows:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; medical decision making of at least moderate complexity during the service period; face-to-face visit within 14 calendar days of discharge **(CPT 99495)**
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; medical decision making of high complexity during the service period; face-to-face visit within 7 calendar days of discharge **(CPT 99496)**

Behavioral Health Integration Services[26]

Behavioral Health Integration (BHI) services are considered an effective strategy in improving mental or behavioral health outcomes for Medicare beneficiaries. Medicare makes payment to physicians and non-physician practitioners for BHI over a calendar month service period. BHI services include Psychiatric Collaborative Care (CoCM) services and General BHI.

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[26] United States. Centers for Medicare and Medicaid Services Medicare Learning Network. Department of Health and Human Services. *Behavioral Health Integration Services*. Vol. ICN 909432. January 2018.

CoCM services utilize the primary care setting to provide care management support for patients receiving behavioral health treatment and regular psychiatric inter-specialty consultation to the primary care team, allowing them to assess patients whose conditions are not improving.

CoCM care team members include:

- *Treating (billing) practitioner:* A physician and/or non-physician practitioner (PA, NP, CNS, CNM); typically, primary care, but may be of another specialty (e.g., cardiology, oncology)
- *Behavioral Health Care Manager*: A designated individual with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight and direction of the billing practitioner
- *Psychiatric Consultant:* A medical professional trained in psychiatry and qualified to prescribe the full range of medications
- *Beneficiary:* The beneficiary is considered a member of the care team

For CoCM, Medicare allows the following:

(CPT Code 99492) Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional;
- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- Review by the psychiatric consultant with modifications of the plan if recommended;
- Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

(CPT Code 99493) Subsequent psychiatric collaborative Care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the

treating physician or other qualified health care professional, with the following required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
- Monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

(CPT Code 99494) Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (list separately in addition to code for primary procedure).

General BHI services are utilized when services other than CoCM are furnished, such as systematic assessment and monitoring, care plan revision for patients whose condition is not improving adequately, and a continuous relationship with a designated care team member. General BHI services may be used to report models of care that do not involve a psychiatric consultant nor a designated behavioral health care manager (although such personnel may furnish General BHI services).

General BHI care team members include:

- *Treating (Billing) Practitioner:* A physician and/or non-physician practitioner (PA, NP, CNS, CNM); typically, primary care, but may be of another specialty (e.g., cardiology, oncology, psychiatry)
- *Beneficiary:* The beneficiary is considered a member of the care team
- *Potentially Clinical Staff:* The service may be provided in full by the billing practitioner. Alternatively, the billing practitioner may use

qualified clinical staff to provide certain services using a team-based approach. These clinical staff may, but are not required to, include a designated behavioral health care manager or psychiatric consultant.

For General BHI, Medicare allows:

(CPT Code 99484) Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, per calendar month, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team.

Conclusions

This care management guide was developed to provide rural hospital executive and management teams a practical approach to understanding care management. The guide provided opportunities to improve performance within the hospital setting and to increase knowledge and understanding of a value-based, population health-focused reimbursement environment. Our hope is that this guide will increase awareness of care management and serve as a "how-to" for managing hospital and ACO or alternative payment components of care management, which are crucial to achieving the following:

- Improving overall population health, with a focus on patients with complex health care needs
- Reducing total cost of care
- Reducing readmissions through best-practice care transitions
- Supporting and facilitating delivery of timely, appropriate care and services to patients and/or members of an ACO
- Facilitating effective inpatient care management, comprised of utilization review and discharge planning

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 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 per month
- Number of acute IP with one-day stay due to being placed in observation then requiring a 2nd midnight, creating a one-day IP stay
- Number of observation discharges who returned to ED and/or observation or Acute IP within seven 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 enough)

- 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 two-day stay without receiving the second IMM letter

Appendix B: Utilization Review Assessment

Best Practices Regarding Utilization Review Processes

- Build relationships with providers by educating them on CMS compliance and payors regulations/requirements
- Develop a close working relationship with the coders to discuss documentation findings/needs
- Ensure the understanding of the 96-hour ALOS CAH rule for CoP vs. the 96-hour LOS for CAH condition of payment from Medicare
- Educate regarding potential impact in managing the GMLOS under PPS
- Ensure all staff and providers understand the 2 MN rule
- Provide InterQual or Milliman guidelines education
- Educate staff on Condition Code 44 and when to apply it
- Ensure the organization has a hospital UR Medical Director or Physician Advisor and back-up
- Educate staff on when to consult with UR Medical Director or Advisor
- Schedule Discharge planner and UR hours based on workload
- Create cheat sheets with names of payors, contact person, what each payor expects, and per diem when applicable
- Establish process to periodically audit documentation to support decisions regarding level of care
- Ensure timely signatures to be obtained (admitting and discharge IMM, 96-hour certification for CAHs, HINN notices)
- Develop a process to 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
- Attend the internal coding training to improve knowledge of documentation needs especially with ICD-10
- Provide house supervisors, ED physician and staff training regarding IP vs. observation and the 2 MN rule
- Facilitate effective Utilization Management meetings
- Review Medicare chart requests/denials and create educational opportunities from findings

Appendix C: Discharge Planning Data Tracking

Data tracking regarding discharge planning and disposition is an important step to help identify what the organization is doing well and any potential opportunities for improvement.

- Disposition status (percent to home, SNF/SB, ARU/IRF, transferred to another acute care facility, etc.)
- 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
- Potential reasons for readmission such as:
  - Patient/Family did not understand medication and did not take as planned
  - Patient/Family did not understand special instruction for self-management
  - Patient/Family did not follow-up with PCP
  - Patient/Family did not pick up prescription due to financial issues
  - Patient/Family did not pick up prescription due to unpleasant side effects
  - Patient did not have transportation
  - 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

Appendix D: Discharge Planning Assessment

Review of Best Practices Regarding Discharge Planning Processes

- Discharge planners or care managers should meet with Patient/Family on the day of admission or at least within the next workday to begin discharge planning discussions
- Patient/Family should be provided with a business card with name and contact information
- Discharge planner or care manager should sit with the patient/family and explain that they are meeting to discuss whether they will have the help they will need when they leave the hospital (including transportation and financial support)
- Discharge planner or care manager should explain options for discharge and take patient preferences and those of their family or caregiver into account in deciding what their health care needs would be when they leave the hospital
- A discharge planning documentation form should be used to ensure all information is addressed (psychosocial needs, support, financial needs, etc.)
- Discuss Advance Directives and document discussion and/or obtain a copy for the medical records from those who have an advance directive
- Round with the provider(s)if possible. If not, huddle post rounding to discuss all information gathered.
- Discuss discharge needs, plans and options with the provider within the second day of admission, including plans for post-acute care needs
- Ensure that the patient has a timely follow-up appointment with their physician post-discharge
- Make sure all documentation is available to the team (physicians, nurses, therapists)
- Implement a daily interdisciplinary discharge planning meeting (IDT) that is short, concise, informative, and efficient
- Request hospitalist (when applicable) participation in the IDT meetings
- Complete a risk for readmission assessment on all patients

- Complete a readmission assessment for those unplanned readmissions (within 30 days)
- Involve patient and family members in all discharge planning activities
- Utilize a Discharge Preparation Checklist to ensure that the patient/family feels comfortable with their readiness for discharge (also referred to as a Discharge Timeout)
- Ensure patient education process contains handouts that are easy to understand and follow
- Ensure medication reconciliation process is completed
- Create a community resources guide that 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.
- Ensure discharge disposition process adheres to CMS requirements

Appendix E: Processes to Improve Care Transitions

- Meet with PCPs in service area to discuss their needs regarding patient care management
- Tabulate the information obtained from readmission assessments and post-discharge follow-up calls or visits to help identify needs
- Create 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
- Utilize clear and concise chronic disease specific instructions across the continuum of care
- Review education material with a group of patients to ensure materials are easy to understand
- Implement a process for medication reconciliation that includes the patient/family, the PCP, the local pharmacists, the specialists, the hospital, the NH and HH
- 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
- Consider using available 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
- Consider using foundation or auxiliary funding to provide items such as scales, B/P cuffs, medication for those in need
- Investigate grant opportunities to fund chronic disease management program, purchase a transportation van, train health coaches, etc.

Appendix F: Resources

SAMPLE ASSESSMENT AND SCREENING TOOLS AND CARE PLAN TEMPLATES:
- Sample Comprehensive Assessment Tool and Self-Management Action Plan template
- Patient-Centered Care Plan template
- PHQ-2 Patient Health Questionnaire-2
- PHQ-9 Patient Depression Questionnaire
- Alcohol and Drug Usage Screening Tool
- Sample Social Determinants of Health Screening tool

MOTIVATIONAL INTERVIEWING RESOURCES:
- Motivational Interviewing Resources from SAMHSA-HRSA
- ADEPT Motivational Interviewing Tools and Techniques
- CCNC Motivational Interviewing (MI) Resource Guide

STANDARD OF PRACTICE RESOURCE:
- CMSA Standards of Practice for Case Management

Appendix G: 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.

SOURCE:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-32.pdf