Managing LOS: 
Case Management’s Response to the New Value 
Based Purchasing Efficiency Measure

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**FACULTY**

**Toni G. Cesta, Ph.D., RN, FAAN** is Partner and Health Care Consultant in Case Management Concepts, LLC, a consulting company which assists institutions in designing, implementing and evaluating acute care and community case management models, new documentation systems, and other strategies for improving care and reducing cost. The author of eight books, and a frequently sought after speaker, lecturer and consultant, Dr. Cesta is considered one of the primary thought leaders in the field of case management. Dr. Cesta writes a monthly column called “Case Management Insider” in the Hospital Case Management journal in which she shares insights and information on current issues and trends in case management. Prior to her current work as a case management consultant, Dr. Cesta was Senior Vice President – Operational Efficiency and Capacity Management at Lutheran Medical Center in Brooklyn, New York.

**Bev Cunningham, RN, MS** is Vice President, Resource Management at Medical City Dallas Hospital. Her areas of responsibility include Case Management, Health Information Management, Clinical Documentation Integrity, Patient Access and Transplant Financial Services. Bev is a well-known speaker in the Case Management field. Involved in the development of case management for over twenty five years, her areas of expertise include denials management, patient flow and the role of the Case Manager and Social Worker in the Case Management process. She has served as a Commissioner on the Commission for Case Management Certification. Bev is also a partner and consultant in Case Management Concepts, a company that provides support to hospitals regarding effective Case Management model development and evaluation. Bev’s publications include a chapter in CMSA’s Core Curriculum for Case Management Certification and most recently, co-author of the book, Core Skills for Hospital Case Management. She is also on the advisory board for Hospital Case Management.
LEARNING OBJECTIVES

- Describe the new value-based purchasing efficiency measure.
- Identify key strategies for managing case management’s impact on the new value-based purchasing efficiency measure.
- Develop an effective team for collaboration to effectively manage LOS.
- Explain new and revised case management standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate case management protocols and penalties.
SUPREME COURT RULING ON HEALTHCARE REFORM:
7 IMPERATIVES FOR FINANCE EXECUTIVES

1. Articulate accountable care strategy
2. Enhance sophistication of financial modeling
3. **Chart a course to Medicare breakeven**
4. Enhance accountability for cost performance
5. Facilitate access to Medicaid coverage
6. Prepare to respond to exchange-based health plans
7. Engage finance staff
### VALUE BASED PURCHASING DOMAINS AND MEASURES

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THE FIRST EFFICIENCY MEASURE

- 3 days prior
- Hospital admission
- 30 days post discharge
- Transfers and readmissions included

INCLUDES PART A AND PART B SPENDING
EFFICIENCY MEASURE: MEDICARE SPENDING PER BENEFICIARY

- Claims-based measure used in both the Hospital IQR and VBP programs
- Controls payment determinations for FY15 and beyond
  - Baseline period: 1/1/12 through 12/31/12
  - Performance period: 1/1/14 through 12/31/14
- Assesses Part A and Part B beneficiary spending during a Medicare spending per beneficiary episode: spans from 3 days prior to a hospital admission through 30 days after patient discharge (originally proposed to be 90 days post discharge); transfers, readmissions and additional admissions are included in this 30 day episode
- Goal: encourage hospitals to be more cost efficient—looking for a lower number rather than a higher number
- Measure adjusted for age and severity of illness
MEDICARE SPENDING PER BENEFICIARY MEASURE SCORES

- Achievement threshold set by CMS at the median Medicare spending per beneficiary across all hospitals during the performance period
  - Hospital with a score above the achievement threshold would receive zero points
  - Hospital with a score at or below the achievement benchmark would receive 10 points
  - All other hospitals will receive from 1 to 9 points

- Improvement score
  - Hospital with score equal to or higher than baseline would score 0 improvement points
  - Hospital with score at or below achievement benchmark would receive 10 points
  - Hospital with score lower than baseline period score, but above benchmark would receive 1-9 points
The "Spending per Hospital Patient with Medicare" (Medicare Spending per Beneficiary) measure shows whether Medicare spends more, less, or about the same per Medicare patient treated in a specific hospital compared to how much Medicare spends per patient nationally. This measure includes any Medicare Part A and Part B payments made for services provided to a patient during the 3 days prior to the hospital stay, during the stay, and during the 30 days after discharge from the hospital.

This result is a ratio calculated by dividing the amount Medicare spends per patient for an episode of care initiated at this hospital by the median (or middle) amount Medicare spent per patient nationally.

A ratio equal to the national average means that Medicare spends ABOUT THE SAME per patient for an episode of care initiated at this hospital as it does per hospital patient at the average hospital nationally.

A ratio that is more than the national average means that Medicare spends MORE per patient for an episode of care initiated at this hospital than it does per hospital patient at the average hospital nationally.

A ratio that is less than the national average means that Medicare spends LESS per patient for an episode of care initiated at this hospital than it does per hospital patient at the average hospital nationally.

Lower ratios mean Medicare spends less per patient.
WHO IMPACTS MEDICARE SPENDING PER BENEFICIARY

- Any care provider along the care continuum
- Family
- Patient
- Does not include Medicare Part D
MEDICARE SPENDING PER BENEFICIARY
STAKEHOLDERS: EXTERNAL

- Care providers immediately before patient admitted to hospital
- Care providers 30 days after hospitalization
- Family
- Patient
MEDICARE SPENDING PER BENEFICIARY
STAKEHOLDERS: INTERNAL

- Care providers
- Family
- Patient
IT’S REALLY BACK TO THE BASICS:
THE 4 FUNCTIONS OF CASE MANAGEMENT

► Utilization Management
► Care Coordination
► Discharge Planning
► Resource Management
TODAY’S CASE MANAGEMENT FUNCTION:
CARE COORDINATION

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.

National Center for Biotechnology Information
5 KEY ELEMENTS OF CARE COORDINATION

1. Numerous participants are typically involved in care coordination
2. Coordination is necessary when participants are dependent upon each other to carry out disparate activities in a patient's care
3. In order to carry out these activities in a coordinated way, each participant needs adequate knowledge about their own and others' roles, and available resources
4. In order to manage all required patient care activities, participants rely on exchange of information
5. Integration of care activities has the goal of facilitating appropriate delivery of health care services.

National Center for Biotechnology Information
LENGTH OF STAY AND TRANSITION TO NEXT LEVEL OF CARE PROVIDER **OVERHAUL**

- Turn over for examination
- Repair
- Take apart to examine it and repair, if necessary
- Process of restoring and maintaining
- To examine or go over carefully for needed repairs
WHAT IS THE EXPECTED LOS?

- Average Medicare LOS 4.8 (National Hospital Discharge Survey 2010)
- Expected LOS is impacted by complications and comorbidities from ICD-9 codes—soon to be ICD-10 codes
- Expected LOS may vary by group providing the results
- Geometric length of stay (GMLOS)
  - Mean: national mean length of stay for each DRG as determined and published by CMS
- Compare your ALOS to the GMLOS
- Case mix adjust your ALOS by dividing your ALOS by your case mix index
WHY DO WE CARE ABOUT LENGTH OF STAY?

- Most payers pay by the DRG
- If a patient stays in the hospital long enough, they will get sick
- LOS is publicly reported
- Gauges hospital efficiency
- Attract managed care contracts
- Maintain competitive edge
- Align with regional and national benchmarks
- Now used for value based purchasing
WHAT IMPACTS LENGTH OF STAY?

- Patient flow
- Case management’s focus on the process of coordination of care
- Captain of the ship physician
- Consulting specialist timeliness
- Delays in care
- Availability of ancillary services
- Timeliness of tests and reporting
- Ability to schedule procedures and tests timely
WHAT IMPACTS LENGTH OF STAY?

- Avoidable days
- Ineffective (or effective) discharge planning
- Unfunded/underfunded patients with minimal resources post discharge
- Availability of post acute care resources, often geographical
- Effective communication
- Focused treatment for the reason the patient was admitted (not focusing on “rabbit trail” treatment)
WHAT IMPACTS THE EXPECTED LOS?

- Coding
- Complications
- Documentation
- Clinical documentation improvement (CDI) effectiveness
WHY WE CARE ABOUT DOCUMENTATION

- Clinical information is our most valuable asset
- Drives reimbursement
  - Case mix index (CMI)
  - Hospital-acquired conditions
  - Next generation of value based purchasing
- Indicates severity
  - Risk of mortality (ROM)
  - Severity of illness (SOI)
  - Complication rates
- Used by public reporting to drive excellence
INPUT:
CLINICIAN’S DOCUMENTATION

BUSINESS OF HEALTHCARE

OUTPUT: RELIABLE AND ACCURATE HEALTHCARE INFORMATION THAT CAN AFFECT EXPECTED OUTCOMES AND REIMBURSEMENT
CARE COORDINATION AND DISCHARGE PLANNING: SEAMLESS TRANSITIONS

SEAMLESS

- Perfectly consistent
- Continuous or flowing
- Having a surface free from roughness or bumps or ridges or irregularities

TRANSITION

- State or passage from state or stage to another
- Alteration of a physician system from state, or condition, to another
- Shifting gears
- Passage from one phase to another
IT’S ALL ABOUT TRANSITION.

And effective transition is the core business of hospitals—and a core responsibility of the case management department.
THE WHY OF TRANSITION PLANNING

Through a situation

From one provider to the next

Through the hospital

Through a disease process

Through the community

To the community
TRANSITION PLANNING

Process in which a systematic approach is used to facilitate the transition of the patient from one level of care to another

- Planning stay from door to door
- Collaboratively determining level of care
- Connecting post-acute care services
- Transitioning patients to next level of care
- Transitional planning = patient flow optimization
TRANSITION PLANNING IS A PROCESS—NOT AN EVENT: A MESSAGE TO THE PATIENT/FAMILY

Sometimes it seems as though discharge from the hospital happens all at once, and in a hurry. But discharge planning is a process, not a single event. Medicare defines discharge planning this way: “A process used to decide what a patient needs for a smooth move from one level of care to another.” As a result of that process, the discharge plan may be to send your relative to her own home or someone else’s, a rehabilitation facility, a nursing home, or some other place outside the hospital. Discharge from a hospital does not mean that your relative is fully recovered. It simply means that a physician has determined that her condition is stable and that she does not need hospital-level care. If you disagree, you can appeal the decision.

From “A Family Caregiver’s Guide to Hospital Discharge Planning”
INFLUENCES ON YOUR PATIENT’S TRANSITIONS

- Physician
- Family
- Patient
- Payers and Regulations
- Case Management Department
- Hospital Issues
- Next Level of Care Delays
INTERDISCIPLINARY COLLABORATIVE IMPACT ON TRANSITIONAL PLANNING

- Bedside rounds
- Effective multidisciplinary discharge planning rounds
- Long stay care conferences
- Unfunded/underfunded care conferences
- Patient/family care conference
- Connect patients to OP services to decrease readmissions
- Discharge lounge
IDENTIFYING THE PATIENT WHO NEEDS CARE COORDINATION

- Chronic condition likely to be readmitted
- Frequent admitter
  - ED
  - Observation
  - IP
- Patients with LOS greater than \( X \) number of days
- Patients of specific physicians
- Patients with specific diagnoses
- Unfunded and underfunded patients
- Those with multiple diagnoses and high charges
- The patient without family dedicated to managing the post acute care transition
LOS STRATEGIES

- Develop LOS goals for predictable populations first: population where there is a likelihood for standardization
- Identify critical team members
- Develop process time frame for goals
  - Pre-hospital phase
  - Hospital phase, including operative phase, if appropriate
  - Pre-discharge phase
  - Discharge
  - Post acute care planning and coordination
  - Possible readmission
LOS STRATEGIES

- For each process time frame identify expectations for the core functions of case management: utilization management, care coordination, discharge planning and resource management
  - Pre-hospital phase
  - Hospital phase, including operative phase, if appropriate
  - Pre-discharge phase
  - Discharge
  - Post acute care planning and coordination
  - Possible readmission
- Weekly tracking
  - LOS
  - Avoidable days
  - Discharge destinations
  - Readmissions
  - Denials
THE MEDICARE CASE MANAGER

- Focus on patients with traditional Medicare
- Coordinate Medicare outcomes
  - ED
  - Hospitalists
  - Other Medicare high-volume admitters
- Collaborate with next level of care providers
- Follow up calls after discharge
- Coordinate all case management functions
  - Utilization management
  - Care Coordination
  - Discharge planning
  - Resource management
- Collaborate with Medicare Social Worker
THE MEDICARE SOCIAL WORKER

- Focus on patients with traditional Medicare
- Coordinate Medicare outcomes
  - ED
  - Hospitalists
  - Other Medicare high-volume admitters
- Collaborate with next level of care providers
- Follow up calls after discharge
- Coordinate all case management functions
  - Utilization management
  - Care Coordination
  - Discharge planning
  - Resource management
- Collaborate with Medicare Case Manager
MEDICARE HOME CARE COORDINATOR

- Follow throughput of home care referrals
- Focus on outcomes of home care agencies
THE MEDICARE CASE MANAGEMENT COACH

- Coordinates roles of case manager, social worker, home care coordinator
- Aligns hospital with all post acute care providers
- Analyzes and reports outcomes
- Collaborates with ancillary and nursing services
- Collaborates with appropriate physician groups
WASTE IN MEDICARE PATIENTS

- Certain readmissions
- Healthcare associated infections
- Adverse drug events
- Unwanted end of life services
- Unrelated diagnostic tests
- Delayed test results
- Delayed scheduling
- Not following physician orders
- No critical thinking for advancement of activity, nutrition, discharge planning
- Contaminated blood cultures

IHI Hospital Inpatient Waste Identification Tool 2011
LONG STAY PATIENT STRATEGIES

- Vulnerable group of patients
- Define long stay: Patients staying longer than a specific number of days, such as 4 or 5 days
- Develop approach
  - Identify the patients
  - Have long stay rounds
  - Partner with your ancillary and nursing colleagues
- Use long stay patients as case studies to improve future lengths of stay
TRANSITION TIME OUT

- From one hospital level of care to another—i.e. medical unit to ICU
- From one practitioner to another
  - Intensivist to hospitalist
  - Case manager to case manager
  - Social worker to social worker
  - Nurse to nurse
- Transition time out topics:
  - Discharge plan
  - Barriers to wellness and barriers discharge
  - Clinical challenges
  - Family challenges
  - Economic challenges
  - Psychiatric challenges
  - Patient challenges
  - Avoidable/delay days
- Team meeting for transition time out of challenging patient: sending team and receiving team; patient and/or family if possible
- Document transition time out
DISCHARGE TIME OUT

- Discharge time out topics
  - Discharge plan
  - Challenges with effective discharge plan
  - Education
  - Core measures
  - Time for follow-up conversation
  - Medication reconciliation
  - Diet
  - DME needs
  - Code status
  - Readmission indicators

- Team meeting for discharge time out of challenging patient: social worker, case manager, discharge specialist, physician, next level of care liaison, staff nurse, pharmacist, appropriate ancillary staff, such as PT

- Document discharge time out
CARE COORDINATION DOCUMENTATION

MEDICAL RECORD
- Outcomes of assessment
- Communication (except with payer), referrals, interventions
- Plan of care (from the assessment)
- Record of interdisciplinary team meetings
- Record of family meetings
- Anticipated discharge date (depending on agreement with physician)
- Discharge disposition

CASE MANAGEMENT SOFTWARE (SEPARATE FROM MEDICAL RECORD)
- Communication with payer
- Variances/avoidable days (in case management software)
- Agreement or disagreement with denials identified by payer
- Anticipated discharge date
The difference in the best case management department, a good case management department, and the worst case management department, isn’t the number of problems they have. The difference is in how they deal with their problems.
ASSESS YOUR DEPARTMENT’S EFFECTIVENESS
EVALUATE YOURSELF IN BEST PRACTICE
STRATEGY CARE COORDINATION

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<th>STRATEGY</th>
<th>IT’S WORKING WELL FOR US</th>
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THE CASE MANAGER, AS CARE COORDINATOR, IS CAPTAIN OF THE MEDICARE EFFICIENCY TEAM
CHARACTERISTICS OF THE EFFECTIVE CASE MANAGER AS CARE COORDINATOR

- Clinical competence and experience
- Timely identification of transition plans
  - Sets milestones, or next steps for patients
  - Acts as liaison with families
  - Facilitates care plan with physicians, nursing and ancillary services
  - Identifies anticipated LOS and updates, as patient transitions
CHARACTERISTICS OF THE EFFECTIVE CASE MANAGER CARE COORDINATOR

- Focuses on evidence based best practices for individuals and groups of patients
- Monitors outcomes
  - Clinical
  - Financial
  - Not just at the end of stay, but throughout the stay
- Understands barriers to transitions for individuals and groups of patients: identifies and intervenes
CHARACTERISTICS OF THE EFFECTIVE CASE MANAGER CARE COORDINATOR

- Evaluates timeliness of transitions
- Assures appropriate documentation of patient’s illness and care
- Identifies performance improvement initiatives
- Consistently tracks and identifies variances/avoidable days
- Assesses, plans, intervenes
- Collaborate with UM, DP, CDI, QM
CASE MANAGEMENT DIRECTOR’S ROLE IN CARE COORDINATION

- Evaluates current staffing ratios and make recommendations
- Identifies and implements appropriate strategies for best outcomes
- Ensures that assigned roles fit individual skill set
- Ensures that staff are equipped with necessary tools and educated appropriately
- Responsible for data gathering and reporting
WORKING WITH THE POST ACUTE CARE VENDOR TO OPTIMIZE YOUR EFFICIENCY RESULT

- Know the most efficient post acute care provider with the best outcomes
- Use your case management software to evaluate these providers
- Provide feedback to the post acute care providers
- Discuss providers with those payers for whom you have managed care contracts
- Adjust your choice letter to highlight those providers with the best outcomes
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Questions???

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