# Case Management Monthly

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## Using embedded case managers to reduce readmissions and streamline care

**Learning objective:**

At the completion of this educational activity, the learner will be able to:

- Discuss best practices and the current enforcement of the 2-midnight rule.

With today's emphasis on population health and better management of patients with multiple chronic conditions, payers and providers are increasingly teaming up to improve care. There's good incentive to do so. Patients with multiple chronic conditions are not only common within the Medicare population, but also use a disproportionate share of Medicare dollars.

"The more chronic conditions an older adult has, the higher the cost of care," said **Joseph Agostini, MD,** national medical director for Aetna Medicare.

One practice—using embedded case managers—has gained support for its success in managing this challenging population, successfully improving patient care, and reducing costs and readmissions. Agostini recently discussed the advantages of this model at

Aetna during an August 26 webinar by HealthLeaders Media called *Using Embedded Case Managers to Reduce Readmissions and Streamline Care.*

While Aetna has been using case managers to improve patient care for more than 10 years, the last five have really been focused on how to make these interventions as effective as possible in coordination with physician groups, he said.

### Using case managers to improve care

Embedded case managers are payer-provided case managers who are tasked with coordinating care between physicians and other healthcare providers. The ultimate goal is to unify the disparate elements of a patient's healthcare experience, which can be a considerable challenge.

The program, which embeds case managers in physician offices, helps to provide one-on-one attention to high-risk patients that need it the most.

The goal, said Agostini, is to effectively:

- Assess the patient's condition and needs

- Help improve the patient's ability to manage his or her condition
- Work with hospitals, physicians, and others to coordinate care
- Efficiently track outcomes and make adjustments when needed

The Aetna nurse case managers are selected not only based on their strong clinical experience as licensed nurses, but also based on their ability to enhance other critical skills, said Agostini, including in areas such as:
- General case management
- Cultural sensitivity
- Motivational interviewing
- Behavioral health
- Advanced-illness management

They work as a team with other professionals, including social workers, pharmacists, behavioral health specialists, and Medicare medical directors, he said.

In their role, case managers look for ways to improve care for patients and to reduce chances for things to slip through the cracks. For example, they may coordinate appointments to make it more likely that a patient will get to the doctor as planned after a hospital discharge, or help ensure the patient has all necessary medical supplies. Case managers may also perform medication reconciliation, educate the patient on self-management, and intervene whenever possible to provide needed support to the patient and other caregivers to help the patient avoid a hospital visit or readmission, said Agostini. The Aetna Compassionate Care Program is one care specialized model. Its focus is on improving care for patients with advanced illnesses. This program pulls in patients who are identified as high risk by a computer analysis or by a case manager, or are referred by a physician office or patient inquiry.

One goal of the program is to make members more aware of available resources to improve their quality of life, such as in-home services, palliative care resources, or hospice benefits, where appropriate. Many patients don't know what services hospice offers. As awareness increases, so does the likelihood that Medicare beneficiaries get care that aligns with their own goals, according to Agostini. The hospice election rate in the Compassionate Care program is 82%. Interventions through this program have seen results, including a:
- 77% drop in ED visits

- 86% fewer ICU days
- 82% drop in acute inpatient days

## Setting goals for change

When creating a care model for high-risk patients, focus on desired outcomes and track your data carefully to ensure you're hitting those targets. "We think about population management support in a straightforward manner," said Agostini. "Who is at risk and who has the opportunity to achieve a better outcome?"

Next, determine what interventions will meet those needs. Among the metrics that embedded case manager programs seek to improve are readmissions. With CMS imposing penalties on organizations that have too many 30-day readmissions, there's incentive to work on avoidable utilization through better care coordination.

In FY 2016, Agostini said it's estimated that some 2,600 hospitals will face CMS penalties for too many hospital readmissions.

"We usually set a goal in the single digits for our Medicare readmission rate, and through the valuable work of partnering with providers in the community, [we] have achieved that goal in probably the majority of groups that focus on readmission prevention," he said.

Advanced illness programs are one way to reduce readmissions, said Agostini. Aetna's case managers provide support to members in their last six to 12 months of life. The goal is to open up a dialogue about the patient wishes, and also address pain and other symptoms as the illness progresses.

It's always a good idea to ensure that your measures are chosen carefully. "Our focus is on standardized outcome measures that are transferrable across health plans and focus on chronic conditions that are prevalent in the population," said Agostini.

## Look to the success of others

Organizations with case management programs should not only track their progress against their own goals, but also look to emulate established best practices.

The Commonwealth Fund last year released an issue brief called, Caring for High Need, High Cost Patients: What Makes for a Successful Care Management Program (*www.commonwealthfund.org/publications/issue-briefs/2014/aug/high-need-high-cost-patients*).

This report outlined the best practices of 18 successful complex care management programs. Aetna was one of the successful models featured, said Agostini, for its use of proven strategies such as team-based care, identifying high-risk patients, and care coordination. Organizations should take note of the identified best practices in this report, he said.

People also matter. Having visible and motivated clinical champions and the ability to change and adapt over time can also determine whether your program will succeed.

## Facing down challenges

While embedded case manager programs can bring benefits, they also have some challenges that organizations will need to overcome, including:
- Getting the right data that can be used to guide the program
- Building strong relationships across different care teams
- Ensuring seamless communication between providers and team members
- Finding space for case managers to work in physician offices
- Navigating different electronic health record systems in different organizations
- Stationing case managers in certain locations where there are people in need

But if an organization can overcome these challenges, they do stand to benefit from a well-run program. "You can't underestimate the ability to provide advice and support to people and their the family and caregivers," said Agostini. Many questions often go unanswered when a person leaves a doctor's office, so having this ability to follow up and provide additional support can bring significant value, said Agostini.

Ultimately, teamwork between payers and providers using embedded nurse case managers can make a difference in the older adult population, said Agostini.

"In the future, from my perspective, the ability to collaborate in new ways and bring new clinical models to the medical space will bring us the greatest opportunity to improve population health and improve quality for older adults and also improve the cost of care. We can achieve a lot by working together," said Agostini. ◨

# Get ready for the NOTICE Act

**Learning objective:**

At the completion of this educational activity, the learner will be able to:

• Identify the requirements instituted under the NOTICE Act.

A new notification requirement is coming next summer. Under the law, the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which was signed by President Barack Obama on August 6, any patient in observation who has been in the hospital for more than 24 hours must be clearly told—verbally and in writing—of his or her outpatient status. Hospital officials have to deliver this notification no more than 36 hours after the patient's outpatient treatments begin.

The goal of the legislation is to ensure patients are aware of their status and what it might mean for them financially—in particular, how it might affect their post-acute care options. To comply with the rule, hospitals will now need to designate someone—in some cases it may be the case manager—to provide this notification.

There might also be some issues to hash out when it comes to the notification form itself. "I hope CMS develops a standardized form that can be used across all states," says **Jackie Birmingham, RN, MS,** vice president emerita, clinical leadership, for Curaspan in Newton, Massachusetts. "They have mentioned doing that and it would be so helpful for hospitals not to have to develop a form and wonder if it meets requirements."

Some states have already put notification rules like the NOTICE Act in place, including Vermont, where a new requirement is set to kick in in December. As part of this rule (*http://ow.ly/S6JKl),* the state will provide hospitals with a standardized notification form that they can give to patients. The state's department of health has started work on this form, but it was not yet complete as of September, according to a Vermont Department of Health spokesman.

## The background

The goal of this new notification law is to help patients better understand their status during treatment. Patients often (wrongly) assume that if they're in a hospital bed, they are an inpatient. They also don't understand the implications of outpatient billing.

"Some clinicians also don't understand the difference and the impact. Bringing this discussion out in the open will help all involved to understand their own responsibility in assuring the patient is in the correct 'status,' " says Birmingham. "Clinicians outside the Case Management department do a terrific job of caring for the patient, but need to also become business partners and at least understand the importance of the paperwork."

One of the biggest issues that can crop up when a patient's care orders place him on observation status is that he will not be eligible for Medicare coverage for a postacute stay in a skilled nursing facility (SNF), and instead may need to pay more out of pocket. Medicare currently only covers SNF Extended Care Rehabilitation services for patients who had three consecutive inpatient days in a hospital. For example, one day in observation and two days as inpatient equals three days in the hospital, but does not meet the three-day inpatient day stay requirement.

"An Office of Inspector General (OIG) report found that the average out-of-pocket cost for SNF services not covered by Medicare was more than $10,000 per beneficiary," states a press release issued by the congressional leaders who promoted the bill (*http://ow.ly/S6JSB).*

The goal of the bill was to help prevent seniors from experiencing "sticker shock" from an unexpected bill, according to the release. Legislators said in the press release that current trends with regard to observation status made the bill timely.

"A study published in Health Affairs found that the ratio of hospital observation stays to inpatient admissions increased by 34% between 2007 and 2009. The same study also found that the number of observation stays exceeding 72 hours has increased by 88%," said the press release. It's possible that this has occurred because hospitals are concentrating on reducing their readmission rates, says Birmingham, and want to be sure that an inpatient stay is really required.

## Complying with the NOTICE Act

To comply with this new notification law, hospital

communications with patients have to check a number of boxes. The ultimate goal is to clearly spell out the patient's status, and potential billing implications.

The law states that the notification must:

- Explain the individual's status as an outpatient and not as an inpatient, and the reasons why
- Explain the implications of that status on services furnished (including those furnished as an inpatient), in particular the implications for cost-sharing requirements and subsequent coverage eligibility for services furnished by a SNF
- Include appropriate additional information
- Be written and formatted using plain language and made available in appropriate languages
- Be signed by the individual or a person acting on the individual's behalf (representative) to acknowledge receipt of the notification, or if the individual or representative refuses to sign, the written notification is signed by the hospital staff who presented it

**Stefani Daniels, RN, MSNA, CMAC, ACM,** founder and managing partner of Phoenix Medical Management, Inc., in Pompano Beach, Florida, says she thinks that access management staff members would be the natural choice to oversee the notification requirement. "When a patient is registered for inpatient hospital care, the access management staff members make sure the patient, or his or her representative, signs off on all required documents including the beneficiaries discharge appeal rights contained in the IM," says Daniels. "Similarly, if the patient is placed in observation, so too must the access management staff make sure the patient signs off on the required NOTICE. That's my position and the access management staff must be held accountable for complying."

Hospital administration can ease this process by having a separate observation unit for patients. "If the hospital cohorts observation patients in a clinical decision unit (CDU) with good signage, it makes it a lot easier for the access management personnel to develop a process that is fool-proof," says Daniels. "If the hospital executive team continues to place outpatients in inpatient beds scattered all over the hospital, it will pose a more complex solution to make sure that no patient falls through the cracks." (Read more about the arguments for and against separate observation units in the January 2015 **CMM** article *The Pros and Cons of Separate Observation Units*.) Status changes may present another challenge for organizations when it comes to NOTICE compliance. If a patient is registered as an inpatient but is then switched to observation services, access management is typically notified, says Daniels. "But I can also tell you that responses by access management to make the necessary registration changes are not always timely or completed," she says. This may be due to staff or technical challenges. They must get it right every time, she says.

Notifying the patient in accordance with the law will require a team effort. "Making sure everyone on the patient's team reminds each other and the patient of the observation status and the implications of that status and to do whatever is necessity to reach a timely decision on whether or not to admit," says Daniels. ⊞

## Continuing education information

**Nursing Contact Hours (ANCC)**

HCPro is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

2.5 Contact Hours for nurses are available each quarter (March, June, September, December).

**Commission for Case Manager Certification (CCMC)**

This program is approved by the Commission for Case Manager Certification for 6 Continuing Education Units per quarter.

To obtain your contact hours you must:

- Read each issue of **Case Management Monthly** within the quarter
- Successfully complete and submit the quarterly quiz (offered in the March, June, September, and December issues; passing score is 80%)
- Complete and submit the evaluation

Each quarter's continuing education hours expire after one year.

**Disclosure statement:**

The planners, authors, and contributors for this CNE activity have disclosed no relevant financial relationships with any commercial companies pertaining to this activity.

# Answering your toughest questions about the 2-midnight rule

**Learning objective:**

At the completion of this educational activity, the learner will be able to:

- Identify best practices when it comes to the 2-midnight rule and understand the current enforcement climate.

If your organization is like many others, you've probably still got some lingering questions about how to comply with the 2-midnight rule. During a recent HCPro webcast "Medical Necessity Documentation and Short Stays," **Steven Greenspan, JD, LLM,** vice president of regulatory affairs at Executive Health Resources in Newtown Square, Pennsylvania, and **Kurt Hopfensperger, MD, JD,** vice president of compliance and physician education for Executive Health Resources, tried to shed some light on areas of confusion.

Below is a summary of some of the questions they answered during the webinar and in the Q&A session that followed.

**Q** **We have a very busy ED and many patients arrive at the hospital before midnight, but don't actually leave for the hospital floor until after midnight. What does CMS consider acceptable when it comes to starting the clock in terms of counting midnights?**

**A** In a December 23, 2013, guidance document, CMS stated that the clock starts at the time the patient's actual care is initiated. Often, a patient will be checked in to the hospital and will receive triage services, such as blood pressure check, or will have his or her temperature taken. CMS does not consider these services to be the start of medical care, because they are given to any patient who comes into the ED, regardless of his or her condition. CMS says the clock actually starts when the medical personnel, the nurse, or physician begin treatment for that patient based on his or her individual condition.

**Q** **When does the clock start ticking in order for a patient to achieve the three consecutive inpatient calendar days needed to qualify for skilled nursing facility services?**

**A** In this case, the clock starts on the day of admission. But keep in mind the day that the patient is discharged from the hospital does not count as a hospital inpatient day. Time spent on observation status or in the emergency department before the patient is admitted as an inpatient also does not count toward this three-day qualifying stay.

Note that the he Medicare Payment Advisory Commission is currently considering proposing revisions to this policy which would count time spent in outpatient observation status toward this three-day stay—provided at least one of the days was spent as an inpatient.

**Q** **How are organizations doing when it comes to compliance with the 2-midnight rule as it stands?**

**A** Information on compliance with the 2-midnight rule is hard to come by. Not all Medicare Administrative Contractors (MAC) have posted their probe and educate results. The information that is out there shows that organizations may be struggling. For example:

- First Coast Service Options listed a 33% denial rate
- National Government Services listed a 65% denial rate in February 2014, but the organization's website shows that 75% of claims were denied
- Palmetto GBA shows denial rates ranging from 55% in West Virginia to as high as 71% in North Carolina
- Novitas doesn't have published denial rates, but informational handouts given to providers shows 46% of claims were denied because of inadequate documentation to support the 2-midnight expectation

**Q** **Many physicians have asked me, "How am I supposed to know how long a patient will be in the hospital? I don't have a crystal ball, how can CMS expect me to predict the future?" Does CMS have any guidance on what standards physicians are held to when**

**a reasonable expectation of 2-midnights is required?**

**A** I have heard this question a fair amount. CMS does not expect you to have a crystal ball, but they did give us some guidance on this topic in the December 23, 2013, document mentioned above. CMS said to make this determination the physician has to look at the individual's condition, taking into account how sick the patient is, the severity of their signs and symptoms, their individual risk factors. This means that a physician might expect two patients with the same condition to have a different length of stay. The expectation is calculated looking forward, it's a reasonable estimate based on the information you have on hand at the time the decision is made. It's not determined by looking back.

**Q** Does outpatient time toward the 2-midnight rule begin at the time of actual treatment or at the time the order is written for observation status?

**A** The time for computing the 2-midnight benchmark begins when the patient first starts to receive services. For example, if the patient is treated in the ED, the clock starts ticking at that point. Similarly, if the patient is transferred in from another facility, the clock starts at the time he or she started being treated at the initial facility, not at the time the order is written.

**Q** The average length of stay is available in our electronic system for all our common DRGs and admitting diagnoses. Our physicians are using this information to make inpatient and observation status determinations. For example, if the average length of stay for a DRG or admitting diagnosis is greater than two days, then they will determine that the patient needs to be inpatient. If the average stay is less than two midnights, then they assign a patient to observation status. Do you have any thoughts on practice, and is this done at other hospitals?

**A** I actually have seen it done, but not very commonly. The problem with doing this is that CMS expects an individual assessment of each and every patient or beneficiary to determine if the physician can reasonably expect him or her to need two midnights of care. It's the history of the individual patient, his or her

comorbidities and individual risk factors, that must determine the stay expectation. Using the average stay for a given condition doesn't take these individual factors into account. In addition, the stays listed in the system are just an average. That means that a number of patients will need a stay less than the amount listed and others more. This number might not also take into account time spent in the ED or when the patient was on observation status. So using this average as an expectation for all patients could lead to problems.

The only time this data could potentially be useful is in the extremely rare situation when a physician is so unfamiliar with a diagnosis that he or she simply has no idea what to expect in terms of stay. But even then, looking at the average stay for the condition would only be one data point out of dozens or hundreds of others that the physician should consider when determining whether a patient will likely need 2-midnights or longer of acute care.

**Q** How can CDI and UR work together to accomplish the needed documentation to support an inpatient admission?

**A** This will vary by hospital, but ideally these two groups should work closely. CDI tends to lift all boats, making physicians more aware of documentation requirements, which can make life easier for UR. CDI efforts can help physicians to understand concepts they have to use to explain a decision; for example, why a patient is risky enough to warrant an inpatient admission. UR and CDI should not be separate or work in silos, because they are in the position to greatly help one another.

**Q** CMS requires an inpatient order to be signed and dated prior to the start of surgery. Does the CMS Transmittal 3217, issued in April 2015, have any effect on this requirement?

**A** There is a potential impact. The guidance set forth tha tfor inpatient-only procedures where there is not an order on the chart, if there is a subsequent admission to the hospital related to the inpatient procedure that the inpatient procedure rolls up into the three-day window and could potentially be included in the DRG for admission. But for this to happen, the procedure provided must be related to the admission. ⊞

## Utilization management versus CDI: What's the difference?

Sometimes different jobs, such as utilization management (UM) and clinical documentation improvement (CDI), have similar roles. To make sure that each job is done effectively, you need to carefully outline each role. Below is a chart created by The Center for Case Management in Wellesley, Massachusetts, that you can use as a starting point to clarify the responsibilities of UM and CDI. (See the related story in the "From the Director's Desk" insert in this month's issue of **CMM**.)

| Utilization management | Clinical documentation improvement |
|---|---|
| Concurrent or retrospective review of the medical record and application of criteria (InterQual® or Milliman Care Guidelines®) to ensure the patient care, clinical condition, and treatment are provided at the right time and level of care. | Concurrent review or retrospective review of the medical record to ensure documentation is as complete and specific as possible, and the provider's information has the specificity required to capture the level of severity of anatomical sites or diagnoses, etiology of symptoms, risks, and complexity of care. |
| Communication with physicians/providers to ensure orders and documentation supports the level of care and treatments required. This communication is often informal and made directly via oral communication with the physician/provider of what clarification is required to support medical necessity for a review. | Formal method of communication with physicians/providers via the use of query forms identifying the need to clarify clinical documentation and ensure documentation is at the level required to clarify ambiguous, incomplete, or conflicting documentation in the medical record and ensure specificity that is required for retrospective health information management coding accuracy. |
| Capturing of data for relaying information to third-party payers for authorization of the services rendered and immediate reimbursement for services rendered.<br><br>Capturing of data for reporting and quality improvement initiatives a hospital may undertake as they relate to denial management, avoidable days, length of stays, admits per thousand, readmissions, and adverse events (i.e., present on admission or hospital-acquired conditions). | Capturing of data as it relates to the classification systems and translating the clinical documentation into codes MS-DRG (Medicare severity-diagnosis related group) or ICD-10 or CPT codes for not only reporting purposes but equally as important for the safeguarding of revenue integrity should the results of an audit place the hospital at risk of a fine or reimbursement. |
| Prospective issuance of applicable notices of non-coverage by third-party payers, when services are determined to not meet medical necessity. | Retrospective defense against billing claims, denials, Recovery Audit Contractor audits, or other third-party audits, and/or suspected malpractice or fraudulent billing. |

*Source: The Center for Case Management in Wellesley, Mass. Reprinted with permission.*

# Utilization management and clinical documentation improvement as synergistic process

*by Peggy Rossi, BSN, MPA, CCM*

To meet CMS requirements to capture adequate and relevant data for reimbursement, quality reporting, and profiling, hospitals need to expand their coding processes. Most hospitals have established formal programs and departments whose sole responsibility is to perform the reviews necessary to capture accurate documentation and then code the data accurately.

Historically in a hospital setting, data collection occurred after a patient was discharged. This task was accomplished by a health information management (HIM) professional assigned to check the patient's medical record to look for discrepancies that might hinder proper code assignment for diagnoses and/or procedures that were performed during hospitalization. The codes assigned would then be used for billing and reimbursement purposes. However, when CMS implemented the prospective payment system (PPS) for hospitals, coded data, which was needed not only for reimbursement but also other reporting, took on a whole new meaning. Thus, accuracy of documentation by physicians and providers became paramount and required the addition of clinicians to work closely with physicians and providers to ensure the data contained the specificity of clinical documentation as it relates to:

- Quality of care issues/measures/compliance and risk
- Pay for performance
- Value-based purchasing
- Data needed for healthcare reform decision-making
- Minimization of vulnerability during external audits
- Other state or federal healthcare reporting initiatives

## Current State

Although both clinical documentation improvement (CDI) and utilization management (UM) job duties appear on the surface to be the same, they are not. For this reason, both roles must have carefully outlined policies and procedures to follow as well as their own job descriptions that outline the unique differences. While both roles use a concurrent and retrospective review process to reach their goals, there are differences between the roles and the business functions they perform for a hospital. (See related chart on p. 8 of this issue of **CMM**.)

With the advent of CDI processes and how the department is established and duties are performed, either all CDI specialists and coders report to HIM, or coders report to HIM and CDI specialists report to the vice president of quality, chief financial officer, or director of case management (as a subspecialty within case management). Success will depend on how well staff members can collaborate. Collaboration is required, as it is often the nurse performing the UM reviews that may discover issues that require further actions by the CDI nurses. The same will be true for the CDI staff if they discover issues that affect discharge outcomes or other quality improvement activities.

## The future

I anticipate that at some time, most hospitals will implement what is known as a triad model in order to free registered nurse (RN) case managers and care coordinators of the UM role to manage both inpatient and outpatient care. It also seems logical that UM and CDI would become a centralized service to larger health systems and accountable care organizations. If that happens, regardless of whether the staff members are in the same physical space or not, the UM/CDI expert would also be an RN and would be a vital source of information for the RN case manager/care coordinator and the ordering physician. If the combined role of UM and CDI is in a health system that uses 90-day bundled payments, the expert that fills said role will also be the source of information to the case manager/care coordinator for the various costs per case (based on level of care decisions), depending on the treatment plan. ⬥

# A case where everything that can go wrong, does

Sharon is a case manager whose patient, Mr. Jones, is in the ICU and has reached "end of life status," and his attending physician deems him "care measures only or CMO."

Because Mr. Jones is a Medicare A and B beneficiary, Sharon follows the CMS Conditions of Participation, and asks the attending physician when he expects the patient will expire and if the patient is "imminently dying." Sharon needs to know whether the physician expects the patient to expire in two weeks, which is the definition of imminent death. If two weeks is the expectation, then the patient would qualify and could access his Medicare A benefits to cover the costs and remain in the hospital until his death. If the time for expiration exceeds two weeks, Sharon will need to establish an alternative plan for care outside the hospital.

The attending physician says the patient's life can be expected to continue for six months or even up to 12 months, which means the patient is not imminently dying. Sharon knows now that having Mr. Jones remain in the hospital is not an option. She questions why the patient has been made CMO, to her this seems like a premature judgment, but the family and patient had accepted the decision and it is documented in the hospital record.

Before approaching the family with a plan, Sharon comes up with alternative potential, post-hospital placement options that include placement in a skilled nursing facility if the patient qualifies with skilled needs, placement in a hospice house if this meets the patient/family wishes, and discharging the patient home with home care and hospice. Before Sharon can discuss the transfer options with the patient/family, the medical resident tells them Mr. Jones can stay in the hospital for two more weeks, in which time he would expire.

Sharon must explain to the medical resident the error in his communication and then reach out to the attending physician to update him on the status of the case. After that, she needs to speak with the patient and his family.

When Sharon presents the transfer options to the family, they are angry about the confusion and the lack of clarity in communications. Despite their dissatisfaction, they listen to Sharon and seem to participate in the planning. Ultimately, they decide to take Mr. Jones home with the support of home care and possibly hospice.

Sharon speaks to the family daily. She provides the family with choice of a home care and hospice service, and begins to order a hospital bed for the home, along with the durable medical equipment and respiratory and infusion company care. Everything seems to be progressing, and although the family shows signs at times of being reluctant to take their family member home, they are cooperative.

Sharon never suspects that their anger is growing, but this soon becomes clear, when the Medicare Quality Improvement Organization (QIO) calls to inform her that the patient/family is appealing the discharge. Immediately, Sharon informs the QIO that it is not possible for the family to appeal the discharge, because there is no discharge date nor is there a physician discharge order. However, since the patient/family has filed an official appeal, Sharon needs to file a formal appeal challenge of her own. The QIO sends her the proper form and she completes it and faxes it immediately. The next morning, the QIO sides with Sharon and the hospital and informs the family that they cannot appeal the discharge until the physician order is written.

Sharon knows that this dissatisfaction of Mr. Jones and his family must be addressed by offering the family some extra efforts from herself and the physician team. Together, they hold another family meeting. During this session, Sharon learns that the family is completely overwhelmed by the thought of taking Mr. Jones home to die. They are not acquainted with this healthcare option and need time to adjust to it. Ultimately, the family and the healthcare team agree on a discharge date. This decision extends the length of stay by four days, but supports the family's wish to have more time to get ready.

Looking back on the case, Sharon remembers each aspect that created a barrier to a smooth transition, but in conclusion, is comfortable with the outcome, which provided the family the time they needed to prepare for the challenges ahead. ◫