Dial-In Instructions

Conference Name: The Transfer-DRG expansion: Case management strategies for maximum safety and reimbursement
Scheduled Conference Date: Thursday, April 20th, 2006
Scheduled Conference Time: 1:00 p.m.–2:30 p.m. (Eastern), 12:00 p.m.–1:30 p.m. (Central), 11:00 a.m.–12:30 p.m. (Mountain), 10:00 a.m.–11:30 a.m (Pacific)
Scheduled Conference Duration: 90 Minutes

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2. If you should need technical assistance during the audio portion of the program, please press the star (*) key followed by the 0 key on your touch-tone phone and an operator will assist you. If you are disconnected during the conference, dial 800/910-4685.

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2. If you prefer not to ask your question on the air, you can fax your question to 877/865-4210 or 973/237-3904. However, note that you can only fax your question during the program.

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In your materials on page 2, we have included a Program Evaluation Letter that has the URL link to our program survey. We would appreciate it if when you return to your office you would go to the link provided and complete the survey.

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We realize that your time is valuable, so we’ve limited the evaluation to a few brief questions. Please click on the link below.

http://www.zoomerang.com/survey.zgi?p=WEB22562XMT8NP

The information provided from the evaluation is crucial towards our goal of delivering the best possible products and services. To insure that your completed form receives our attention, please return to us within six days from the date of this audioconference.

We appreciate your time and suggestions. We hope that you will continue to rely on HCPro audioconferences as an important resource for pertinent and timely information.

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Sincerely,

Frank Morello
Director of Multimedia
HCPro, Inc.
The Transfer-DRG expansion: Case management strategies for maximum safety and reimbursement

A 90-minute interactive audioconference

Thursday, April 20, 2006

1:00 p.m.–2:30 p.m. (Eastern)
12:00 p.m.–1:30 p.m. (Central)
11:00 a.m.–12:30 p.m. (Mountain)
10:00 a.m.–11:30 a.m. (Pacific)
In our materials, we strive to provide our audience with useful, timely information. The live audioconference will follow the enclosed agenda. Occasionally our speakers will refer to the materials enclosed. We have noticed that other non-HCPro audioconference materials follow the speaker’s presentation bullet-by-bullet, page-by-page. Because our presentations are less rigid and rely more on speaker interaction, we do not include each speaker’s entire presentation. The materials contain helpful forms, crosswalks, policies, charts, and graphs. We hope that you find this information useful in the future.

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Web site: www.hcpro.com
Dear colleague,

Thank you for participating in our “Transfer-DRG expansion: Case management strategies for maximum safety and reimbursement” audioconference with June Stark, RN, BSN, MEd, and Jean O’Leary, BSN, CRRN, CCM, MPA/H, moderated by Jeff Anderson. We are excited about the opportunity to interact with you directly and encourage you to take advantage of the opportunity to ask our experts your questions during the audioconference. If you would like to submit a question before the audioconference, please send it to stierney@hcpro.com and provide the program date in the subject line. We cannot guarantee that your question will be answered during the program, but we will do our best to take a good cross-section of questions.

If at any time you have comments, suggestions, or ideas about how we might improve our audioconferences, or if you have any questions about the audioconference itself, please do not hesitate to contact me. And if you would like any additional information about other products and services, please contact our Customer Service Department at 800/650-6787.

Along with these audioconference materials, we have enclosed a fax evaluation. We value your opinion. After the audioconference, please take a minute to complete the evaluation to let us know what you think.

Thanks again for working with us.

Best regards,

Shannon Tierney
Audioconference coordinator
Fax: 781/639-2982
E-mail: stierney@hcpro.com
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   B. Most important 10–20 DRGs for hospitals to focus on

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   B. What’s happening nationally

IV. DRG Case Studies
   A. Surgical
   B. Medical

Live Q&A
Speaker profiles

Jeff Anderson, Moderator

Jeff Anderson is an Associate Editor at HCPro. He edits Case Management Weekly an ezine and Case Management Monthly, a newsletter for hospital case managers and directors, and helps research and develop training products within the Nursing/Case Management group.

June Stark, RN, BSN, MEd

June Stark is the director of case management at North Shore Medical Center in Salem, MA, which includes Salem and Union Hospitals. She also acts as an associate consultant for the Center of Case Management in Natick, MA. Stark previously held the position as director of care management at St. Elizabeth’s Medical Center in Boston and participated in the development of case management at New England Medical Center in the 1980s.

Jean O’Leary, BSN, CRRN, CCM, MPA/H

Jean O’Leary is a case manager at North Shore Medical Center in Salem, MA. She is the coordinator of the Presurgical Orthopedic Assessment program, which was initiated in January 2006. Her prior case management experience includes her serving as director of case management at HealthSouth New England Rehabilitation Hospital (NERH) in Woburn, MA; case manager and program manager of the Spinal Cord Injury Program at NERH; and medical/vocational case manager at John Hancock Mutual Life Insurance Company.

O’Leary received a bachelor of science degree in nursing in 1977 and a master’s in program administration/health in 1989. She is certified in rehabilitation nursing and case management. She is active with and has been on the board of directors for the Case Management Society of New England and Greater Boston Chapter of National Spinal Cord Injury Association (GBC). In 2002, O’Leary was the inaugural recipient of the Service Excellence Award, given by Case Management Society of America, and the Lifetime Achievement Award from the GBC.
Exhibit A

Presentation by June Stark, RN, BSN, MEd, and Jean O’Leary, BSN, CRRN, CCM, MPA/H
The Transfer DRG Expansion: Case Management Strategies for Maximum Safety and Reimbursement

June Stark, RN, BSN, MEd
Director, Case Management
Jean O’Leary, BSN, CCM, CRRN, MPA/H Case Manager
North Shore Medical Center

Why Transfer DRG’s?

- Strategy of the Balanced Budget Act to preserve Medicare funding
- The message to hospitals is unclear

Experts suggest
- Treat patients over a longer length of stay (LOS), and discharge to home when possible
- Reduce hospital reimbursement
A patient transfer is not a Transfer DRG

General Impact

- CMS estimated a 0.9% reduction in reimbursement
- American Hospital Association predicted $4 billion over 5 years
Case Manager Awareness, Knowledge and Understanding of Transfer DRGs...

Wise Decision Makers

Transfer DRG’s – Historical Perspective

- 1997 – 10 Transfer DRG’s
- 2002 – 29 Transfer DRG’s
- 2006 – 182 Transfer DRG’s
1997 – 10 Transfer DRG’s

- Identified the highest costing DRG’s
- The majority of Medicare dollars were spent on first 10 transfer DRG’s
- Eliminate “double dipping”
- The diagnoses very likely to require a post acute stay for rehabilitation

1997 – 10 Transfer DRGs

- 014 – Intracranial Hemorrhage or Stroke with infarct
- 113 - Amputation for Circulatory System Disorders Except Upper Limp and Toe
- 209 – Major Joint Limp Reattachment Procedures of Lower Extremity
- 210 – Hip and Femur Procedures Except Major Joint Procedures With CC
- 211 – Hip and Femur Procedures Except Major Joint Procedures Without CC
- 236 – Fractures of Hip and Pelvis
- 263 – Skin Graft and/or Debridement for Skin Ulcer or Cellulitis With CC
- 264 – Skin Graft and/or Debridement for Skin Ulcer or Cellulitis Without CC
- 429 – Organic Disturbances and Mental Retardation
- 483 – Tracheostomy Except for Face, Mouth and Neck Diagnosis
The Transfer-DRG expansion: Case management strategies for maximum safety and reimbursement

**Standard Rule: Medical Transfer DRG Reimbursement**

- Identify total potential payment for the DRG
- Calculate the daily payment
- Day 1 the hospital receives twice the daily reimbursement
- The remaining reimbursement is divided over GMLOS minus 1 day

**For example**

<table>
<thead>
<tr>
<th>DRG 127</th>
<th>CHF</th>
<th>GMLOS is 4.1</th>
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<td>Maximum reimbursement is $4888</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day One</td>
<td>Day Two</td>
<td>Day Three</td>
</tr>
<tr>
<td>$3258</td>
<td>$815</td>
<td>$815</td>
</tr>
</tbody>
</table>

**Medical Transfer DRG Calculation**

1. Step 1: Determine Full DRG Payment
2. Step 2: Divide DRG Payment by GMLOS minus 1 day. Get Daily Payment
3. Step 3: Assign Day 1 double the amount of the daily payment
4. Step 4: Take remaining amount and divide by number of days, starting with day 2, but not including discharge day.

Example: CHF GMLOS 4 days, Reimbursement $4888. Take $4888 and divide by 3 days. Get $1629/day. Now double $1629 to obtain Day 1 reimbursement, which is $3258. Remaining amount is $1630, which will be divided by 2 remaining days. Results in a payment of $815 for Day 2 and Day 3.
The Transfer-DRG expansion: Case management strategies for maximum safety and reimbursement

EXHIBIT A

Standard Rule: Surgical Transfer DRG Reimbursement

- Identify total potential payment for the DRG
- The hospital receives 50% of the transfer DRG for Day One
- The remaining 50% of the transfer payment is divided over the remaining GMLOS minus 1 day

For example

<table>
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<tr>
<th>DRG</th>
<th>GMLOS</th>
<th>Maximum reimbursement is $9278</th>
</tr>
</thead>
<tbody>
<tr>
<td>544</td>
<td>4.1</td>
<td></td>
</tr>
</tbody>
</table>

Day One   Day Two   Day Three   Day Four/Discharge
$4639     $2319.50  $2319.50  

Surgical Transfer DRG Calculation

Step 1: Determine Full DRG Payment
Step 2: 50% of Full DRG Payment will equal reimbursement for Day 1
Step 3: Remaining amount will be divided over GMLOS minus 1 day

Example: Joint Replacement GMLOS 4.1 reimbursement $9278. 50% of $9278 equals $4639 which is the Day 1 payment. Take remaining amount, divide over remaining days up to GMLOS minus 1 day. Therefore Day 2 payment is $2319.50. Day 3 is $2319.50.
Transfer DRG Reimbursement

Hospitals receive the full reimbursement for a discharge if patient length of stay is one day less than the GMLOS

2002-Then there were 29 DRG’s...

- 12 – Degenerative Nervous System Disorders
- 14 – Intracranial Hemorrhage or Stroke with Infarct
- 24 – Seizure and Headache, Age < 17 With CC
- 25 – Seizure and Headache, Age >17 Without CC
- 88 – Chronic Obstructive Pulmonary Disease
- 89 – Simple Pneumonia and Pleurisy, Age > 17 With CC
- 90 – Simple Pneumonia and Pleurisy, Age > 17 Without CC
- 113 – Amputation for Circulatory System Disorders Except Upper Limp and Toe
- 121 – Circulatory Disorders with Acute Myocardial Infarction and Major Complications, Discharged Alive
- 122 – Circulatory Disorders with Acute Myocardial Infarction without Major Complications, Discharged Alive
- 127 – Heart Failure and Shock
- 130 – Peripheral Vascular Disorders With CC
- 131 – Peripheral Vascular Disorders Without CC
- 209 – Major Joint Limp Reattachment Procedures of Lower Extremity
29 DRG’s continued

- 210 – Hip and Femur Procedures Except Major Joint Procedures Age > 17 With CC
- 211 – Hip and Femur Procedures Except Major Joint Procedures Age > 17 Without CC
- 236 – Fractures of Hip and Pelvis
- 239 – Pathological Fractures and Musculoskeletal and Connective Tissue Malignancy
- 263 – Skin Graft and/or Debridement for Skin Ulcer or Cellulitis With CC
- 264 – Skin Graft and/or Debridement for Skin Ulcer or Cellulitis Without CC
- 277 – Cellulitis, Age > 17 With CC
- 278 – Cellulitis, Age > 17 Without CC
- 294 – Diabetes, Age > 35
- 296 – Nutritional and Miscellaneous Metabolic Disorders, Age > 17 With CC
- 297 – Nutritional and Miscellaneous Metabolic Disorders, Age > 17 Without CC
- 320 – Kidney and Urinary Tract Infections, Age > 17 With CC
- 321 – Kidney and Urinary Tract Infections, Age > 17 Without CC
- 395 – Red Blood Cell Disorders, Age > 17
- 429 – Organic Disturbances and Mental Retardation
- 468 – Extensive O.R. Procedure Unrelated to Principal Diagnosis
- 483 – Tracheostomy Except for Face, Mouth and Neck Diagnosis

2006 – Now there are 182 Transfer DRG’s

- Almost half of the DRG’s are Transfer DRG’s
- 52% of Medicare discharges nationwide are Transfer DRG’s
- **Transfer-Adjusted Case Payment**
  - **Standard Rule** (169 of the 182 Transfer DRG’s)
    - Short stays-start by figuring out the transfer adjustment rate/your risk
  - **Special Rule** (13 of the 182 Transfer DRG’s)
What did transfer DRG’s create?

- A new method of Medicare reimbursement
- Not the traditional “lump sum” DRG payment
- A per diem payment that is adjusted per length of stay and disposition
  - Patient goes home with no services
  - Patient transfer to home care or a facility, then the hospital receives a payment that is adjusted accordingly
…so, the accurate discharge disposition is necessary for appropriate Medicare reimbursement

**Case Management system to assure recording of accurate discharge disposition**

**Compliance issues:**
- inaccurate recording of discharge disposition could result in overpayment, putting the hospital at risk for Medicare audit

**Hospital Compliance issues:**
- inaccurate recording of discharge disposition could result in underpayment, putting the hospital at financial risk

---

**Specific Impact: Who Should Consider Managing?**

- Hospitals with a high number of Transfer DRG’s
- Hospitals with a large percentage of short stay Transfer DRG’s
  - Less than full DRG payment for patients discharged more than one day before ALOS
  - Patients referred to a home health agency within 3 days of discharge
  - IRF/ Acute Rehabilitation discharge
  - SNF/Skilled Nursing Facility discharge
- Hospitals with a high surgical volume are more likely to experience a greater financial loss
- Treatment patterns-significant response time to change care
Why would you chose not to manage the transfer DRG?

- High patient volume/need for diversion
- Patient flow
- Meeting the needs of your referral sources
- Compliance issues…near 100% capture of Transfer DRG payments

How to Manage the 182

- Now what?
- How does Case Management manage 182 Transfer DRG’s?
- Where do we start?
- That is what this presentation is all about.
182 Transfer DRGs

- See the Transfer DRG’s Tool (Exhibit B)
- Utilize this tool to identify your “Vulnerability Index”
  - Fill in your hospital’s volume for each DRG
  - Fill in your hospital’s ALOS
  - Take it one step further and add expected vs. observed LOS
  - Take it another step further and add cost per case

Using the Tool: Approaches

1. Use the tool to identify the highest volume 10-20 Transfer DRG’s for your hospital by comparing costs versus reimbursement per case
2. Identify those that show a high frequency of early discharges, determine your risk
3. Focus primarily on surgical Transfer DRG’s
The Two Challenges for Case Management

- Challenge for the Transfer DRG is when the patient LOS is less than the GMLOS.
- Challenge for the DRG payment (not a transfer) when the patient LOS is longer than the GMLOS.

The Bottom Line

What is best for the patient?
**Case Management Considerations**

- Clinical levels: Interqual, MCAP, MR
- Quality of care
- Transfer DRG-Full DRG payment
- Accurate discharge disposition determines the payment
- DRG Payer
  - Coordinate care within the GMLOS
  - Avoid exceeding the DRG in accordance with the accurate patient level

**Compliance Issues**

- The accuracy of discharge disposition
- Variation from previous Medicare practice patterns i.e. increased numbers of longer LOS cases, suggesting extended to maximize Transfer DRG payment
Managing Transfer DRG’s

- Run a monthly report of all Transfer DRG’s to monitor LOS pattern
- Monitor all patients’ LOS and discharge disposition for accuracy

Review of Laws and Regulation... Transferring/Discharging Patients

- Federal Rules for Discharge Planning
- JCAHO standards
- State Department of Public Health Standards
- The patient’s readiness for discharge
Examples of Case Management Interventions

The Goal.....Balance

Best practice
Quality care

Effective
Efficient
Utilization
**DRG 127 Heart failure and shock**

- GMLOS 4.1
- Hospital Example 3
- Stays over 4.1 approximately 71/333
- How to intervene?
  - Care Map with four day length of stay, compliant with core measures
  - Disease Management Program
    - Referral
    - Educational packet
    - Outpatient follow-through

**DRG 209/544 Major joint and limb reattachment**

- GMLOS 4.1
- Hospital Example 3.3
- Stays over 4.1 approximately 49/258
- How to intervene?
  - Pre-surgical case management assessment
  - Identify post acute care choices, make referrals proactively
  - Set up expectations pre-surgically
Pre-surgical Case Management Assessment

- Surgical procedure
- Next of kin
- Health Care Proxy
- Premorbid lifestyle
- Living situation
- Equipment
- Community Resources
- Patient Expectations
- Constraints
  - Insurance criteria, contracts
  - Lack of/ inadequacy of support
  - Environmental barriers
- Education
- Follow-through

GOAL

Pre-surgical case management assessment for all elective surgery patients
Salem Hospital Experience
Post Intervention

- January to March, 2006
- N=61
- Diagnoses     DRG     LOS     Medicare GMLOS
  - Total joints  DRG 544  4.4 days  4.1 days
  - Revision      DRG 545  5.5 days  4.5 days
  - Bilateral     DRG 471  6 days    4.5 days

For single joints
Number of patients discharged < GMLOS = 10 or 83%
Number of patients, discharged < GMLOS, with Medicare/other DRG payer = 9 or 90%
Number of patients discharged < GMLOS, to a facility, 8 or 80%

DRG 88-COPD

- GMLOS         4
- Hospital Example 4.91
- Stays over 4 approximately 35/187
- How to intervene/is intervention necessary?
  - In and outpatient Pulmonary Rehabilitation programs
    - The case manager makes the connection
      - Pulmonary Consult
      - Referrals to inpatient/outpatient, depending on level of care
    - Flu vaccine offered to each patient upon admission/core measure
The Transfer-DRG expansion: Case management strategies for maximum safety and reimbursement

**DRG 014-Intracranial hemorrhage and stroke with infarction**
- GMLOS 4.5
- Hospital Example 4.84
- Stays over 4.5 approximately 12/174
- How to intervene?
  - Code Stroke
  - Neurological rehabilitation
    - The case manager makes the connection
      - Acute IRF
      - SNF/Sub-acute
      - Outpatient
      - Home

**DRG 104-Cardiac Valve Procedures and Other Major Cardiothoracic Procedures with Cardiac Cath**
- GMLOS 12.7
- Hospital Example 12.31
- Stays over 12.7 approximately 5/15
- How to intervene?
  - Pre-surgical case management assessment
  - Identify post acute care choices, make referrals proactively
  - Set expectations pre-surgically
The Importance of Documentation

- Ensure there is complete documentation in the medical record justifying continued stay, as well as a safe, and clearly articulated discharge plan.
- Ensure that medical necessity is balanced with patient advocacy.

Sample Documentation

Mr. Blue is Post Operative Day #3 from left Total Hip Replacement. Hematocrit has recovered to 30.2, after transfusions each of the last two days. He has been febrile to 101.3 the last two evenings. Source is unclear, coverage with po Keflex has been initiated today. His progress with PT has been slow, due to difficulty with pain management. FNB and PCA pump are discontinued today. He is receiving narcotics on a scheduled basis. He is still at hospital level of care at this time.

Referrals have been made to a Hospital-based TCU and several SNFs in the area. A preferred home care agency has also been identified. They are following for medical stability for transfer. Mr. Blue was made aware that his SNF rehabilitation benefit is limited to 80% up to $10,000. However, the frailty of his significant other precludes home discharge at this time. This writer will follow with you for discharge when and where appropriate.

RN, CCM, Case Manager
Conclusions and Recommendations

- Transfer DRG’s encourage hospitals to embrace “Best Practice”
  - Within each Transfer and/or Medicare DRG, identify a cohort of patients that are more likely to be discharged home
  - Develop strategies to support them in doing so
- Utilize transfer DRG’s as an opportunity to develop and review Clinical Paths/Care Maps
- Utilization management of LOS/resources is possible with Transfer DRG’s
- Discharge disposition accuracy and monitoring is essential
- Monthly monitoring of Transfer DRG compliance issues

Conclusions and Recommendations

- Partner with Physicians-designated CM/MD teams
- Partner with post acute providers
  - IRFs
  - SNFs
  - Home care agencies
- Ensure smooth transitions for patients and their families.
HCFA/CMS/HER Study in 2000

- How are hospital practices responding to the initial 10 transfer DRG’s?
- Comparison of payments and costs for the cases coded as Transfer DRG’s
- Are hospitals getting around the 1997 policy by delaying post acute care transfer, or, by coding the patient’s discharge status as something other than a transfer?


Health Economics Research Study in 2000

- Identified cases by linking acute hospital discharges with post acute records, instead of discharge coding
- First two quarters of fiscal 1998
- Findings
  - A slight decrease in short-stay post acute transfers (those with LOS at least one day below the geometric LOS)
  - Moderate decline in the number of post acute care transfers paid for under the per diem method
  - Possibly, hospitals are keeping patients in the 10 DRG’s longer prior to transfer, at least until GMLOS minus 1

Conclusions: “The marginal reactions by hospitals suggests that the increase in post acute transfers over the past few years has been due to a number of factors, of which Medicare payment has been only one.”

How Much Is Post acute Care Use Affected by Its Availability?

- Study published in 2005, IRF vs. SNF transfers
- Studied hip fractures, stroke or joint replacements (DRG’s 210, 014, 544)
- Factors
  - Distance to providers
  - Supply of providers
  - Impact of hospital system continuum
  - Ease of referrals
  - Accessibility of providers
  - Premorbid level of functioning
  - Availability of caregivers
  - Patients/families expectations
  - Data not available re: post acute rehabilitation producing better functional outcomes

Conclusion:
“Greater supply leads to either greater use of post acute care and better outcomes, or unwarranted expenditures of resources and delays in returning patients to their homes.”

Health Services Research, April 2005, pp.413-434.

The Future

- Lots of payers moving to DRG payments.
- Medicare may make all 559 DRG’s into Transfer DRG’s.
- There are proposals linking reimbursement to effectiveness of stay, defined by sustained outcome, or patients’ ongoing functional gain.
Questions

Thank you.
Exhibit B

182 Medicare Transfer DRGs FY06 Chart

Source: June Stark, RN, BSN, MEd and Jean O’Leary, BSN, CRRN, CCM, MPA/H. Reprinted with permission.
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<th>DRG</th>
<th>DRG TITLE</th>
<th>FY05 RELATIVE WEIGHTS</th>
<th>FY06 RELATIVE WEIGHTS</th>
<th>FY 05 GEO MEAN LOS</th>
<th>FY 06 GEO MEAN LOS</th>
<th>YOUR HOSPITAL VOLUME</th>
<th>YOUR HOSPITAL LOS</th>
<th>EXPECTED VS. OBSERVED</th>
<th>COST PER CASE</th>
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### The Transfer-DRG expansion: Case management strategies for maximum safety and reimbursement

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* FY06 POSTACARE CARE SPECIAL PAY TRANSFER DRG

NOTE: RELATIVE WEIGHT NOT AVAILABLE IN FY05

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR TRANSFER CASES

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.
Exhibit C

References

Source: June Stark, RN, BSN, MEd and Jean O’Leary, BSN, CRRN, CCM, MPA/H. Reprinted with permission.
The Transfer DRG Expansion: Case Management Strategies for Maximum Safety and Reimbursement

References


Stineman, Margaret G., MD et al “Challenges in Paying for Effective Stays,” Medical Care. September, 2005, pp.841-3.


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**NEW! Case Management Institute:** Managing by influence to maximize the effectiveness of your case management program

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April 6-7, 2006, The Ritz-Carlton Hotel, Phoenix, AZ

**Effective JCAHO Survey Preparation for the Medical Staff**

The JCAHO is seeking to re-engage physicians in a new, more dynamic survey process. Train your physicians and their teams on what to do when they disagree with the surveyor’s findings, the 2006 standards and patient safety goals, documentation challenges, and much more.

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April 7, 2006, The Westin Hotel, Michigan Avenue, Chicago, IL

**NEW! Discharge Planning Summit**

Decrease denials, maximize length of stay, and increase efficiency. Learn how to comply with significant federal regulations and use your discharge planning process to support the business side of healthcare. You’ll walk away from this summit with strategies to boost revenue without losing sight of the needs of the patient.

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Get concrete steps to make your medical staff quality program truly effective. Learn how to encourage positive physician performance, create effective physician performance feedback reports, solve the challenges of peer review, improve hospital systems, and address clinical performance problems.

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**Advanced Medical Staff Leadership Retreat:** Where today’s leaders come to solve their toughest medical staff problems

Get an in-depth look at the six toughest challenges faced by medical staff leaders today: ED coverage, disruptive physician behavior, physician/hospital collaboration and competition, matching proven competency with clinical privileges, physician/physician and physician/hospital conflict, lack of effective physician leaders.

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**Surgical Team Summit:** Bringing together chiefs of surgery, chiefs of anesthesia, and surgical services leadership to tackle the toughest OR challenges

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Spring 2006 Seminar Calendar

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**NEW! Core Privileging Advanced Course: Design and implementation**
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Ask about additional discounts!

May 18–19, 2006, Mandalay Bay Resort & Casino, Las Vegas, NV

**UPDATED! The 9th Annual Credentialing Resource Center Symposium**
Learn practical and innovative approaches to solving your toughest credentialing and medical staff challenges. For the past nine years, experts from The Greeley Company have offered medical staff and credentialing professionals nationwide seminars on credentialing hot topics. Past topics have included low-volume/no-volume providers, core privileging, physician performance profiles, new technology, and much more.

**Early-Bird Discount:** Register by March 16 to save $100!

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**UPDATED! Achieving Continuous Survey Readiness Through Patient Tracers: A practical 5-step model to compliance**
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**Magnet Resource Center Advanced Workshop**
Confused and overwhelmed by how to achieve Magnet status—the highest seal of nursing excellence? Then attend this seminar to work one-on-one with the elite few nursing professionals who have already achieved Magnet status. These experts will outline clear action plans toward successful completion of your Magnet application.

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May 20, 2006, Mandalay Bay Resort & Casino, Las Vegas, NV

**NEW! Physician Performance Profile Course: Quality data and current competence**
Understand the collection and use of quality data to improve physician performance and appraise the ongoing competence of your medical staff. Topics include the domains of physician performance, the use and application of rule, rate and review indicators, and gaining physician buy-in.

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**JUNE**

June 1–2, 2006, The Ritz-Carlton, Amelia Island, Amelia Island, FL

**Medical Executive Committee Institute: The essential training program for all medical staff leaders**
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