I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which an Affiliate either manages or controls the day-to-day operations of the facility (each, a “Tenet Hospital”) (collectively, “Tenet”).

II. PURPOSE:

The purpose of this policy is to define the case management process for utilization review and discharge planning documentation during identified prolonged down-times of electronic medical record and/or case management documentation systems.

III. DEFINITIONS:

A. “Case Management Documentation System” means the case management documentation system that Tenet Hospitals use to document all utilization management and transition planning assessments and processes including, but not limited to, INTERQUAL or other Tenet approved criteria reviews, clinical reviews, secondary physician reviews, transition planning evaluations and plans, referrals for post-acute services and case management tasks and interventions.

B. “INTERQUAL or other Tenet approved clinical screening criteria” mean clinical decision support guidelines licensed for use by hospitals and managed care companies to evaluate the appropriateness of medical interventions and level of care based on clinical criteria and standards.

C. “Authorization/Preauthorization” means a process by which the hospital contacts the payer to seek preauthorization/precertification/authorization for the patient status and treatment ordered by the Admitting Physician.

D. “Transition Management” means the process of assessing and reassessing patients for post-hospital needs and then developing and implementing a plan to coordinate those services identified as necessary for the patient when they leave the hospital. The process includes a mechanism for a Case Management Registered Nurse or Social Worker to identify at an early stage of hospitalization those patients who are likely to suffer adverse health consequences upon Discharge or Transfer if there is inadequate planning.

E. “Case Management” means a collaborative process of assessment, planning, facilitation, care coordination and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes.
F. “Inpatient” means any person who has been admitted to a Tenet Hospital for bed occupancy for purposes of receiving hospital services.

G. “Outpatient” means a person who has not been admitted by the Tenet Hospital as an Inpatient but is registered on the Tenet Hospital records as an Outpatient and receives services from the Tenet Hospital. The duration of services and time of day are not determinative of Outpatient Status. Observation Services are considered an Outpatient level of care.

H. “Observation Services” or “Observation” means assessment, short-term treatment, reassessment, and stabilization before decision to admit to Inpatient or discharge.

I. “Hospital Case Manager” means, for the purpose of this policy, a Tenet Hospital representative appropriately educated in the accurate application of INTERQUAL or other Tenet approved clinical screening criteria. The Hospital Case Manager may be a Tenet Hospital employee or a contractor.

IV. POLICY:

Case Management staff will implement procedures related to hospital admission, continued stay, and transition of care planning as established by Tenet. Documentation standards during downtime (longer than 4 hours) will be as follows.

V. PROCEDURE:

A. Utilization Review Activities

1. Case Management Documentation System Alerts are sent to the hospital Director of Case Management (DCM), Operations, and the Tenet Call Center (TCC) to advise them of information systems downtime, planned or unplanned. Case Management staff will coordinate with TCC and/or Secondary Medical Reviewers.

2. Responsibility for completing reviews during system downtime:

   a. For cases that have been in hospital less than 24 hours, TCC will continue to own the admission review, for those that are to be completed by the TCC, once the Case Management Documentation System is up and running.

   b. For cases that are approaching 24 hours and/or are time sensitive (Medicare admission reviews or insurance authorization submissions) the Hospital Case Manager (HCM) will complete the review.
3. When the Case Management Documentation System is down, and for INTERQUAL reviews that are to be completed by the HCM, the review will be conducted utilizing the medical record documentation against hard copy INTERQUAL Book criteria if available.

If the INTERQUAL Book criteria are not available, the HCM will conduct a clinical review summary and enter an INTERQUAL review into the Case Management Documentation System once the system is up and running.

a. Hard copy review documentation will be recorded on a hospital Case Management Downtime Documentation form.

b. Cases that do not meet medical necessity will follow the established Secondary Review Process.

4. For payers with an authorization process, the HCM will utilize the medical record documentation to create a clinical review summary for the payer. HCM will document this clinical summary on the hospital Case Management Downtime Documentation form and fax this and other pertinent info directly to payer.

5. Once the Case Management Documentation System is back online, HCM will enter the review into the Case Management Documentation System. All appropriate interventions will be entered.

6. If both the Electronic Medical Record (EMR) and Case Management Documentation Systems are down, the same process shall be followed to document clinical reviews utilizing any hard copy documentation that is on the medical record.

7. Once the Case Management Documentation or EMR systems are back online, hospital DCM, Operations, and TCC will receive alerts that the systems are back online and normal operations can be resumed.

B. Transition of Care and Discharge Planning

1. When the Case Management Documentation System is down, all transition of care documentation and discharge planning will be documented on hard copy versions of the Adult or Infant/Child Transitional Assessment forms (see Attachments A and B) for initial assessment, and Reassessment notes, Complex Case notes, and/or Discharge Planning notes for all consecutive assessments.

2. If the patient is discharged, the Final Discharge Disposition note will be documented on a hard copy form. (see Attachment E) Interventions such
as Important Message, Patient Choice etc., will be noted in either the Reassessment or Final Disposition Note and then entered into the Case Management Documentation System when it is back online.

3. All handwritten notes must be dated, timed, and have a patient label attached on it. Notes must be legible and in accordance with hospital handwritten standards (black ink, no highlights, only using approved abbreviations). Case Management staff will sign his/her full name, title and date. Original copy will be placed in the medical record under discharge tab.

4. Once the Case Management Documentation System is back online, notes will be uploaded and appropriate interventions will be entered.

5. If Cerner/EMR is down, HCM staff will continue to utilize the Case Management Documentation System for documentation. Notes will be printed to hard copy and placed on the hard copy medical record.

6. Once Cerner/EMR is back online, HCM staff will insure that notes have crossed over into the electronic medical record.

C. Responsible Person

The Tenet Hospital’s Director of Case Management is responsible for ensuring that all personnel adhere to the requirements of this policy, that these procedures are implemented and followed at the Tenet Hospital, and that instances of noncompliance with this policy are reported to his/her Supervisor and the PMI Senior Director of Case Management.

D. Auditing and Monitoring

Audit Services will audit adherence to this policy as part of the full scope audit process.

E. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Employees who fail to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.
VI. REFERENCES:

- COMP-RCC 4.01 Hospital Discharge Policy for Medicare Patients
- PMI.CMT.102 Requirement for Patient Choice for Post-Hospitalization Services
- PMI.CMT.103 Hospital Case Management Transition Planning
- PMI.CMT.104 Hospital Case Management Utilization Review Process
- Cerner Millennium Downtime Clinical Documentation and Order Entry model policy

VII. ATTACHMENTS:

- Attachment A Adult Transition Evaluation
- Attachment B Infant/Child Transition Evaluation
- Attachment C Complex Case documentation
- Attachment D Reassessment form
- Attachment E Final Discharge Disposition form
Adult Transition Assessment

Setting: □ Admitted □ ED □ Outpatient □ Other

Prior Living Situation Adult
Lives with: (relationship, name and phone #) _____________________________
Is the patient a primary caregiver? □ Yes (for) ___________________________ □ No
Type of dwelling: _____________________________
If the patient is returning, the home lacks the following:
□ Running Water □ Electricity □ Refrigeration (medications) □ Heat
Identified Interventions (specify):
Home modifications: _________________________________________________
DME: ______________________________________________________________
Community Resources: _______________________________________________

Substance use affecting the Adult (If present, task to SW):
□ Alcohol □ Cocaine □ Marijuana □ Methamphetamine □ Other: __________

Current or suspected abuse or neglect:
□ Yes (task to SW) □ No

Agencies/DME company active prior to admission: ______________________________________

Equipment in the home:
□ Cane □ CPAP □ Commode □ Hospital Bed □ Oxygen □ Walker
□ Wheelchair □ Other: _____________________________________

Baseline Assessment:
Location prior to admission:
□ Home
□ Homeless (task to SW)
□ Long Term Care _____________________________
□ Acute Rehab Hospital _____________________________
□ Skilled Nursing Facility _____________________________
□ Specialty Hospital _____________________________
□ Assisted Living Facility _____________________________
□ Other ____________________________________________

Independent with all functional activities of daily living: □ Yes □ No (if checked complete questions below)

Bed Mobility: □ Independent □ Ext Assist □ Lim Assist □ Supervised or dependent □ Unknown
Transfer: □ Independent □ Ext Assist □ Lim Assist □ Supervised or dependent □ Unknown
Eating: □ Independent □ Ext Assist □ Lim Assist □ Supervised or dependent □ Unknown
Grocery shopping: □ Independent □ Ext Assist □ Lim Assist □ Supervised or dependent □ Unknown
Driving: □ Independent □ Ext Assist □ Lim Assist □ Supervised or dependent □ Unknown
Dressing and bath: □ Independent □ Ext Assist □ Lim Assist □ Supervised or dependent □ Unknown
Toilet use: □ Independent □ Ext Assist □ Lim Assist □ Supervised or dependent □ Unknown
Bladder incontinence: □ Yes □ No □ Unknown
Bowel incontinence: □ Yes □ No □ Unknown
Ostomy: □ Yes: (specify) ___________________________ □ No
Catheter: □ Yes: (specify) ___________________________ □ No

Patient or family/ support person is able to provide self-care / care: □ Yes □ No □ TBD
Adult Transition Information
Projected transition date: _________________________

Anticipated transportation plan: _________________________

Plan discussed with: □ Patient □ Caregiver □ Spouse/ Family □ Legal guardian/POA □ Foster parent
□ Friend □ Significant Other □ Other: _________________________

Plan discussed with: (Name and phone #) _________________________

Issues reviewed with caregiver:
□ Post hospital care □ Employment □ Income
□ Healthcare insurance □ Other: _________________________

Does the patient have prescription coverage? □ Yes □ Yes, inadequate coverage □ No

Does the patient qualify for a prescription assistance program? □ Yes □ No

Does the patient have adequate financial resources for copays and deductibles? □ Yes □ No

Care needs over time are expected to: □ Remain Constant □ Lessen □ Increase □ Unable to Determine

Patient Discharge Goals / Discharge Preferences: _________________________

High Risk Screening Criteria:
□ Yes (4 or more major categories –bolded boxes checked below) □ No

□ Behavioral Health / Compliance concerns: □ current treatment for mental illness □ active substance abuse
□ cognitive impairment □ refuses help or assistance such as home health
□ Lack of financial / social support: □ no help or limited caregiving assistance □ homeless □ primary caregiver
for other □ no health insurance □ no primary care MD □ difficulty in getting to primary f/u or prescriptions
□ End of Life Issues identified: □ yes □ no
□ Chronic Conditions: (HF, COPD, ESRD, Cancer, Diabetes, Dementia): □ yes □ no
□ Medication management: □ yes (polypharmacy >10 active medications @home and/or cannot afford) □ no
□ Patient or Caregiver with low degree of understanding in managing disease process: □ yes □ no
□ Non-compliance with plan of care: □ yes □ no
□ Frequent health service utilization: □ frequent utilizer of hospital and/or ED within last 6 months □ currently active with home health services □ readmission within last 30 days(s) □ no primary care MD □ currently resides in skilled rehab facility, nursing home, or assisted living facility

Other Notes:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

CM/ Social Worker Name: _________________________

Date Completed: _________________________
Infant / Child Transition Assessment

Setting:  □ Admitted  □ ED  □ Outpatient  □ Other

Prior Living Situation
Lives with:  □ Parents  □ Foster Parent  □ Legal Guardian  □ Family Member
Siblings:  □ Yes  □ No
Is the patient a primary caregiver?
□ Yes (for) ___________________________  □ No
Type of dwelling:  □ Apartment  □ Facility  □ Homeless  □ House  □ Shelter
If the patient is returning, the home lacks the following:
□ Running Water  □ Electricity  □ Refrigeration (medications)  □ Heat
Identified Interventions (specify):
Home modifications:  _________________________________________________
DME:  _____________________________________________________________
Community Resources:  _______________________________________________
Financial Resources:
□ Employed  □ WIC  □ SSI  □ Public Assistance  □ Food Stamps
□ Other _________________________

Substance use affecting the infant / child
□ Alcohol  □ Cocaine  □ Marijuana  □ Methamphetamine  □ Other: __________
Current or suspected child abuse and or neglect:
□ Yes (task to SW)  □ No
Does the child lack any supplies:  □ Car seat  □ Baby bed  □ Diapers  □ Appropriate clothing (neonatal/winter)
□ Food  □ Other: ________________________
Nutritional Plan:  □ Breast feeding  □ Formula / Tube feeding  □ Other: _________
Agencies/DME active prior to admission:  __________________________________
Equipment in the home:  □ Apnea monitors  □ Nebulizer  □ Oxygen  □ Other ________________________
Educational Child Care:  ________________________________________________
Social Summary:  _______________________________________________________

Infant / Child Transition Plan
Projected transition date:  _________________________
Anticipated transportation plan:  ____________________________
Plan discussed with:  □ Patient  □ Caregiver  □ Conservator  □ Legal guardian  □ Foster parent  □ Family
□ Friend  □ Significant Other  □ Other: ____________________________
Name and phone # of person plan discussed with:  ____________________________
Issues reviewed with caregiver:  □ Post hospital care  □ Employment  □ Income  □ Healthcare insurance
□ Other: ____________________________

Does the patient have prescription coverage?  □ Yes  □ Yes, inadequate coverage  □ No
Does the patient qualify for a prescription assistance program?  □ Yes  □ No
Does the patient have adequate financial resources for copays and deductibles?  □ Yes  □ No

Anticipated transition plan:  ________________________________________________
Patient / Caregiver Goals and Preferences:  _____________________________________
Care needs over time are expected to:  □ Remain Constant  □ Lessen  □ Increase  □ Unknown
Infant / Child Transition Assessment

High Risk Screening Criteria
☐ Yes (4 or more major categories-bolded boxes below)    ☐ No High Risk Issue Identified

☐ Behavioral Health / Compliance concerns:  ☐ Current treatment for mental illness  ☐ Active substance abuse  ☐ Cognitive Impairment  ☐ Refuses help or assistance such as home health
☐ Lack of financial / social support:  ☐ No / Limited caregiver help in home  ☐ Homeless  ☐ Provides care for another  ☐ No health insurance  ☐ Has trouble getting transportation to medical appointments
☐ End of Life Issues identified:  ☐ Yes    ☐ No
☐ Chronic Conditions: (HF, COPD, ESRD, Cancer, Diabetes, Dementia):  ☐ Yes    ☐ No
☐ Medication management:  ☐ Polypharmacy (> 10 active medications at home)  ☐ Has had problems obtaining/affording/taking medications
☐ Patient or Caregiver has low degree of understanding re: how to manage illness:  ☐ Yes    ☐ No
☐ Non-compliance with plan of care:  ☐ Yes    ☐ No
☐ Frequent health services:  ☐ Currently receiving Home Health services  ☐ Hospital or Emergency Department in last 6 months  ☐ No primary care provider  ☐ Readmission within last 30 days  ☐ Currently resides in skilled rehab facility, nursing home or assisted living facility

OTHER NOTES:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

CM/SW NAME:  ______________________________________
Date Completed:  _____________________________________________________________________
Complex Case / Psychosocial Assessment

Patient Information
Patient Name ____________________________________
Medical Record # _________________________________
Room Number ______________ Account Number ____________

Admission Information
Admission Date _______________ LOS ___________ Insurance ___________________________
Readmit Yes / No Patient Type ________________ Gender Male / Female
Primary Dx ______________________ Secondary Dx ______________________
Attending Physician ___________________________________________

Complex Case Review
Discuss in Completed Case Review starting _________________ (Date) _________________(Time)

Notes

Mental Status
Patient is alert and oriented: (Time, Person, Place) Yes / No / Unable to assess baseline

Notes

Mental Status: ___Aggressive ___Apathetic ___Avoidant ___Confrontational
___Confused ___Cooperative ___Delusional ___Depressed ___Fearful/Anxious
___Forgetful ___Intubated ___Lethargic ___Sedated ___Tearful
___Unresponsive ___Withdrawn
Is the patient deemed incompetent or incapacitated: Yes / No
If yes, name and contact of legal representative

Is this a new diagnosis: Yes / No
Does patient accept new diagnosis: Yes / No (If yes, Task to SW)

Behavioral Health Treatment History
Does patient have Psychiatrist: Yes / No
If yes, indicate name

Does patient attend counseling/therapy: Yes / No

Notes:

Does patient have an intensive care manager in the community: Yes / No

Notes

Discussed in Patient Care Conference: Yes / No

Notes
## Complex Case / Psychosocial Assessment

### Patient Information
- **Patient Name**: ________________________________
- **Medical Record #**: ______________________________
- **Room Number**: _____________  **Account Number**: _____________

### Lack of Support System
Financial barriers identified: Yes / No (If Unfunded/No Insurance/Self Pay, refer to Financial Counselor)

<table>
<thead>
<tr>
<th>Notes</th>
</tr>
</thead>
</table>

Social barriers identified: Yes / No

<table>
<thead>
<tr>
<th>Notes</th>
</tr>
</thead>
</table>

Community resource barriers identified: Yes / No

<table>
<thead>
<tr>
<th>Notes</th>
</tr>
</thead>
</table>

Complex clinical needs identified: Yes / No

<table>
<thead>
<tr>
<th>Notes</th>
</tr>
</thead>
</table>

Other issues identified: Yes / No

<table>
<thead>
<tr>
<th>Notes</th>
</tr>
</thead>
</table>

### Medication
Taking prescribed medication(s): Yes / No (If no, address in comments below)

- **Prescription not covered by Ins/Lack of Med F/U**

<table>
<thead>
<tr>
<th>Prescription not filled due to:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Specify prescription(s) not taken:</th>
</tr>
</thead>
</table>

Polypharmacy:

- **How many prescriptions**: _____________

<table>
<thead>
<tr>
<th>Notes</th>
</tr>
</thead>
</table>

Mode of administration:

<table>
<thead>
<tr>
<th>Notes</th>
</tr>
</thead>
</table>

Medication management addressed: (please specify)

<table>
<thead>
<tr>
<th>Notes</th>
</tr>
</thead>
</table>
Complex Case / Psychosocial Assessment

Patient Information
Patient Name ________________________________
Medical Record # ________________________________
Room Number _____________ Account Number _____________

End of Life

Physician identified issue:

Hospice: (Task to SW)

Palliative Care: (Task to SW)

Family/Support end of life issues identified:

Additional Notes not addressed elsewhere:

RN/SW Name: ________________________________
Position: ________________________________

RN/SW Signature: ________________________________ Date: ________________
Reassessment

Patient Information
Patient Name ____________________________________
Medical Record # _______________________________________
Room Number ______________ Account Number _____________

Admission Information
Admission Date _______________ LOS __________ Insurance _______________
Readmit Yes / No Patient Type ________________________
Primary Dx __________________________ Secondary Dx _________________________
Attending Physician ___________________________________________

Reassessment
Anticipated transition date: ______________________

Anticipated transition plan:
___ Acute Rehab   ___ Assited Living   ___ Foster Care   ___ Group Home   ___ Home-No needs
___ Home w/ DME   ___ Home w/ HH     ___ Home w/ self admin IV  ___ Home w/ Community Resources
___ Homeless    ___ Hospice        ___ Inpt Acute Hosp ___ Inpt Psych      ___ IP Substance Abuse
___ Intermediate Care Facility  ___ Jail    ___ LTAC       ___ Medicare transfer DRG
___ SNF placement  ___ Terminal Care  ___ Other - Reassessment Required to Determine Plan

Anticipated transportation plan:
___ Air ambulance  ___ ALS        ___ ALS w/ vent    ___ BLS       ___ Bus (no voucher given)
___ Cab (No voucher given)   ___ Critical Care ambulance  ___ Nonmedical stretcher van
___ Private vehicle   ___ Train    ___ Wheelchair van ___ Other (see Notes)
___ Unresponsive    ___ Withdrawn

Notes:

Discussed with patient: Yes / No
Notes:

Discussed with: (enter name/relationship to patient)
Notes

Discussed in Patient Care Conference: Yes / No
Notes

RN/SW Name: ____________________________________________
Position: ________________________________________________

RN/SW Signature: _________________________________________ Date: ______________________
Final Discharge Disposition Form

Patient Information
Patient Name ____________________________________
Medical Record # _______________________________________
Room Number _______________ Account Number _______________

Admission Information
Admission Date _______________ LOS ___________ Insurance ___________________________
Readmit Yes / No Patient Type _______________ Gender Male / Female
Primary Dx __________________________ Secondary Dx ___________________________
Attending Physician ___________________________________________

Post Discharge Services Ordered:
Patient discharge or transfer with a Planned Acute Care Hospital Readmission: Yes / No
Indicate Final DC Disposition:
___Home-w/self-care, relative, group home, foster care, self-admin IV, homeless, RC, Board&Care, ALF
___Short Term Care PPS Facility - Transfer to Acute Hospital
___Medicare Certified SNF Bed - Transfer to Medicare Certified SNF for skilled care
___Non-Medicare Certified SNF Bed - Transfer to Medicare Certified SNF for skilled care
___Short Term Non-PPS Hospital Services - Children's Hospital, Cancer Hosp, Acute Burn Center Facility
___Home Health Services - Answer questions 2-3 to provide more information below
___AMA ___Expired ___Jail or Prison ___Federal Hospital - Includes VA Hospital
___Home with Hospice ___Hospice Facility
___Medicare Approved Swing Bed, This Hospital & Other Institutions
___Rehabilitation Hospital/Unit - Acute Rehab Facility
___Long Term Care Facility - LTAC at this or other hospital
___Non-Medicare Certified SNF Bed; Medicaid Certified-Medicaid Certified Nursing Home
___Psychiatric Facility/Unit
___Out-patient Services at Other Institution
___Designated disaster alternative care site
___Other Facility Not Classified Above - Provide Name/Type below:

If Home Health, Date Services to Begin: ______________________
If Home Health, Reason for Services:  
___Related to Reason for Admission
___Unrelated to Reason for Admission

Notes

RN/SW Name: ____________________________________________
Position: ________________________________________________
RN/SW Signature: _________________________________________ Date: _______________________

Final Discharge Disposition Form 1