HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

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INSIDE

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Is your staffing ratio appropriate for your case management model?

Educate the C-suite on CM roles and responsibilities, experts say

Provisions of the Affordable Care Act and other health care reform initiatives have made the case management role more important than ever, but in order to help the hospital succeed in the new world of health care, the department has to have adequate staff who are assigned appropriate responsibilities, experts say.

"There has been a lot of attention paid to value-based purchasing, patient satisfaction, accountable care organizations, and population health management, and it all is centered around case management and managing cost across the continuum. Hospital officials are beginning to see that a good case management department makes the difference between sometimes being in the black and being in the red," says **Brian Pisarsky**, RN, MHA, ACM, senior managing consultant at Berkeley

EXECUTIVE SUMMARY

Case managers may be working longer hours and have more responsibilities to help their hospital comply with health care reform initiatives, but before rushing to the C-suite to ask for more staff, case management directors should take a hard look at the roles and responsibilities of the department, experts say. They recommend:

- Look at your staffing ratio and determine if it is appropriate for your case management model and if it is in line with staffing ratios at similar hospitals with similar models.
- Make a list of all the tasks that case managers are asked to do and break out those that don't affect outcomes or cost of care and those that don't require licensure. Get these assigned to other employees.
- Before you approach management to ask for more staff, do your homework and have hard data to back up your request.
- Consider hiring case management extenders to take over clerical tasks and free up case managers to work at the top of their licenses.

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Research Group, with headquarters in Emeryville, CA.

The problem is that every time there's a new initiative from the Centers for Medicare & Medicaid Services (CMS), case managers get another task added to their responsibilities, points out **BK Kizziar**, RN-BC, CCM, owner of BK & Associates, a Southlake, TX, case management consulting firm.

"Historically, if the hospital administration doesn't know what to do with something, they send it to case management. All over the country, I still see case managers who rarely talk to patients or meet the family because they are too busy with assigned tasks. How can case managers develop a workable discharge plan if they never meet the patients?" she adds.

Despite all the attention given to case management, decision-makers at some hospitals still see case management as a cost center, Kizziar says. "Often case managers are used only to meet regulatory requirements, and this doesn't do anything to affect outcomes. It all rolls in together. We are so busy trying to meet regulatory requirements that we are too busy to engage the patient and family to be an active part of their own care," Kizziar says.

Case managers often complain about working long hours and not having time to get everything done, but often it's not a matter of inadequate staffing. It's a matter of roles and responsibilities, Pisarsky says.

"When the case managers are asked to do more tasks than they can handle, it becomes difficult to prioritize their work. Once their priorities become muddled, the important tasks get dropped, and this often has a negative impact on revenue. At some organizations, utilization review doesn't get done or pre-certification doesn't happen, or because nobody has had time to find out about a patient's home situation, you find out on the day of discharge that she has no place to live and she has to stay at least another day. All of this adds up to loss of revenue for the hospital," he says.

Before making the case with the C-suite to add staff, take a long, hard look at the department and analyze the roles and responsibilities of existing staff, Pisarsky advises.

"Throwing more people at the problem is not always the answer. If the process is broken, you have to fix it or adding staff won't change the end result," he says.

Start the process by understanding what your staffing ratio should be, says **Beverly Cunningham**, RN, MS, consultant and partner at Dallas-based Case Management Concepts. Staffing depends on the case management model, she points out. She recommends a ratio of one case manager to 15 patients if the case managers are doing utilization review, basic discharge planning, and care coordination and seeing every patient. Social workers should have a caseload of 17 if they are intervening on 40% of the cases, she says.

Other models would require a different case manager-patient ratio, she adds.

Compare your case manager-to-patient ratios to those in other hospitals with similar models, Pisarsky suggests. "If your department's ratio is close to the national ratios, look carefully at why you need more staff," he says. It could be that case managers are being asked to do things that they shouldn't be doing, he adds. "Could those tasks be moved to another department or a case management assistant be added to do these administrative duties?" he asks.

Cunningham suggests analyzing

data in the five areas where case management interventions can make a difference. These are denials, length of stay, avoidable days, cost per case, and readmissions. Determine if any of the areas are trending upward.

Give particular attention to cost per case and readmissions, because they will affect the Medicare spending-per-beneficiary metric that the Centers for Medicare & Medicaid Services has added to its value-based purchasing beginning in 2015, she adds.

Compare your data with national benchmarks for length of stay, cost of care, and readmissions. "If the department has best-practice staffing, these metrics should be within the benchmarks. If any of these areas are trending higher than the national benchmarks, focus on those areas and determine if it's because you don't have adequate staff or for another reason. Then predict what you can do to impact the trends," she says.

"There's no magic formula. Case management directors have to be able to make a reasonable calculation of where they can make a difference," she says.

For instance, if the cost per case is going up, look at what case managers can do to make an impact. "They can cut length of stays, decrease avoidable days, and decrease readmissions. They all play into the dollar amount in Medicare spending-per-beneficiary. All are interrelated and can be impacted by better discharge planning," Cunningham says.

Make sure your case management staff are doing case management and not 20 other things, Kizziar says. Identify all of the tasks your case managers are doing that benefit no one in terms of outcomes, patient satisfaction, and cost of care. Most of these will be clerical tasks, such as printing documents, faxing nursing homes, or filing patient records, Kizziar says.

Determine how many hours the case managers spend each week on these tasks that are not part of the case management process. Break out how much on clerical tasks and how much on utilization review, she says.

Determine if the right people are being utilized in the right role, Pisarsky adds. "Just because a nurse case manager is in the chart, that doesn't mean they should be doing documentation improvement or completing medication reconciliation," he says.

"THERE'S NO MAGIC FORMULA. CASE MANAGEMENT DIRECTORS HAVE TO BE ABLE TO MAKE A REASONABLE CALCULATION OF WHERE THEY CAN MAKE A DIFFERENCE."

Develop responsibility grids that specify the primary duties and expectations of the case managers and work to eliminate tasks that are not on the grid, Pisarsky suggests. For instance, filling out workers' compensation papers or completing sick notes for patients is not the responsibility of case managers, but they are asked to do these tasks in some hospitals, he says.

Build a dashboard around key performance indicators of the case management department and set goals for each. Look at the results monthly or daily and create easy-to-read graphs showing progress. "If you're not moving toward the goals, there's no question that you need to change directions or processes. If you are not measuring it, you are not managing it," he says.

If the problem is that case managers are doing tasks that don't require their level of expertise, reorganize the department, Pisarsky says.

Adding more case managers isn't the solution to everything, Cunningham adds.

"Hospitals need to have a strong case management director who can manage and mentor people. The director must understand the business case for case management and that case management is a clinical business department. Physician involvement and family involvement are also important. There are a lot of variables that impact the metrics," she says.

For instance, if your goal is to decrease length of stay, look at avoidable days and drill down to find out why patients stay longer than expected. If it's primarily a physician issue, get the chief medical officer involved, Cunningham recommends.

If denials are going higher, drill down to determine whether it's because you don't have adequate staff or for another reason, she adds.

"Many case management departments do not manage their own denials. They are handled by someone in revenue integrity or finance. Case management departments need to have an expert who understand denials processes related to case management and the nuances in denial patterns for individual payers and can educate the staff about what each payer is looking for," she says.

If you really need additional staff, determine if you can cover the responsibilities of the department at a lesser cost, Pisarsky says. Consider hiring case management assistants or referral coordinators to assist the case managers in getting the work done but at a lower salary than a licensed individual would be paid. *(For details on case management extenders, see related article on page 29.)*

Extenders can set up transportation, order durable medical equipment, and make referrals to post-acute providers, Pisarsky says.

"Having case management extenders in the department gives the licensed staff the time to do the work that needs their expertise, which is case management and discharge planning," he says. ■

Have data ready to back up your need for more staff, experts say

Show the financial benefits of your request

Never ask your hospital's management to approve more staff unless you have the evidence for the return on investment for your request, advises **Brian Pisarsky**, RN, MHA, ACM, senior managing consultant at Berkeley Research Group, with headquarters in Emeryville, CA.

Being able to convert what case managers do to dollars is critical, adds **BK Kizziar**, RN-BC, CCM, owner of BK & Associates, a Southlake, TX, case management consulting firm.

"Data is the only thing the C-suite cares about in terms of justification. Case management directors need to provide data, not anecdotal evidence, to make their case," she adds. *(*Case Management Insider*, page 31, has detailed information on case managers' relationship to the hospital C-suite.)*

Case management directors have to demonstrate what can be done monetarily in order to increase staff, Kizziar says.

"If case management directors talk to the chief financial officer about patient satisfaction or touchy-feely things, the CFO is going to roll his or her eyes and thank them for coming in, and do nothing about their request for more staff," Kizziar says.

At one hospital, Kizziar said to the management team, "What would you think if I could save you $200 in costs per patient day, decrease the readmission rate, and increase physicians satisfaction?"

"I had their attention and showed them the blueprint of how I was going to do it. I told them that the case managers have to be at the bedside and round with physicians and talk to families and that they can't do that when they're doing utilization review and clerical jobs," she says.

> "IF CASE MANAGERS ARE BUSY DOING CLERICAL TASKS OR UTILIZATION REVIEW, THEY CAN'T CATCH DUPLICATE PROCEDURES."

Her plan assigned utilization review to utilization review specialists who did nothing but utilization review and set up a resource center staffed by non-clinicians to handle referrals for post-acute needs.

Kizziar reports that she has checked back with that hospital occasionally over the past year and the plan is working.

"In order to justify hiring more staff, case management directors have to convince the C-suite that case managers are orchestrating the symphony by making sure that everything gets done for the patient in a timely manner," adds **Christine Babina**, RN, BSN, a case management consultant in Oxford, CT.

Determine the cost of an excess stay and demonstrate what it means to your organization if the patient stayed in the hospital longer than needed. Multiply the number of excess days by the cost per day, Pisarsky suggests.

Point out that not only did the hospital lose money on the patient who had a longer than necessary length of stay, it lost reimbursement for the patient who could have filled that bed, Pisarsky says.

Tabulate the number of patients who are being discharged late in the day and show that if you can get a patient discharged earlier, patients waiting in the post-anesthesia care unit or the emergency department can get in the bed quicker. "It

improves throughput and helps the bottom line by not having additional expense caring for a patient when you aren't going to get any more reimbursement," he says.

Convert your case managers' actions into dollars, Kizziar suggests. For instance, if a physician orders an MRI and the patient just had one a week ago but the physician hasn't seen the results, the case manager can show the physician the results and document that she prevented the second MRI. The same is true if physicians order a chest X-ray on a pneumonia patient every day.

"If case managers are busy doing clerical tasks or utilization review, they can't catch duplicate procedures. That's the best justification for separating utilization review and case management," Kizziar says.

Another way to show cost savings by case managers is to show how many patient days were saved by case management interventions, Kizziar says. For instance, if you can show that Dr. X typically keeps pneumonia patients five days but they have been being discharged in three days, you can say it could be because of case management interventions.

"But in order to convince the physician that the patient can do fine at home, a case manager has to be on the floor, talking to the doctor, looking at lab work, and talking to patients to find out about their home environment and whether they could manage at home. Case managers have to interact with patients in order to make recommendations to the physician," she says.

Time studies are one tool that case management directors can use to make the case for new employees, Babina says.

To develop a time study, have all your case managers keep a log with them at all times for a week and document every 15 minutes what they are doing and how long it takes.

"Often they don't get to eat and frequently their days are more than eight hours. If a patient is ready for discharge at the end of the day, they can't just go home. Otherwise, they'll be increasing the length of stay and financial ramifications. Case management directors need to be able to demonstrate the long hours case managers work," she says.

At the end of the week, take the logs of all case managers and break each job into steps, she suggests. Add together the time each job takes, then get the median time for each job. "It brings to light what their job is. This way, if they came in at 8 a.m. and didn't leave until 6 p.m., they'll have it written on paper," she says.

Make a note if case managers are doing things that aren't part of their job description, such as assisting patients to the bathroom when there is no staff nurse available.

In one case, Babina persuaded the chief financial officer to shadow a case manager to see what a typical day was like.

"Nobody realizes what a case manager's job entails. The CFO was surprised at how much case managers are expected to do. In this case, it became clear that we needed additional help in the case management department," she says. ■

CM extenders can free up licensed staff to do what they do best

They help with clerical tasks, telephoning

At a time when hiring RN case managers and social workers is a challenge, it may be time to look at hiring case management extenders.

They may be called case management assistants, referral coordinators or case management associates, but the job is the same. They handle clerical work and other jobs that don't require a license, freeing up the case managers to concentrate on tasks that need their expertise.

"If hospitals want to decrease the length of stay and expedite discharges, extenders are vital," says **Christine Babina**, RN, BSN, a case management consultant in Oxford, CT. As a case management director at a large hospital, Babina helped make an existing case management extender program more efficient and effective by implementing discharge planning software. "We amended the program because wanted the nurse case managers to be able to concentrate on complex situations that need a nurse's scope of knowledge rather than spending their time and expertise doing paperwork, faxing, and filing," she says.

Justifying clerical support for case managers to the executive team is often a difficult task, but it can help relieve an overworked staff, says **BK Kizziar**, RN-BC, CCM, owner of BK & Associates, a Southlake, TX, case management consulting firm.

Case managers are doing

everything from copying charts to filing, faxing, phoning, stapling, and writing reports, she adds. "These all take a lot of time but are not part of the actual case management process. As long as case managers are doing clerical jobs and other busywork that keeps them away from the floor and interacting with patients and physicians, the case management department is not going to have maximum success," she says.

Case management extenders are become more prevalent, but the vast majority of hospitals do not have them, says **Beverly Cunningham**, RN, MS, consultant and partner at Dallas-based Case Management Concepts.

If you have case management positions that you can't fill, consider taking a position and turning it into a case management extender position, she suggests.

"An extender can't replace everything case managers and social workers do, but they can support them so they can do the things they do best every day," Cunningham says.

Case management extenders can be trained to help with basic discharge planning tasks, such as giving patients the letter stating they have a choice of post-acute providers. They can do a variety of tasks such as ordering durable medical equipment or running errands for the case managers, particularly if the case managers cover more than one unit, Cunningham says.

Case management extenders should work as a team with case managers and assist them in orchestrating patients' care and the discharge process, Babina says. "Their work can expedite the discharge process and give the nurse case managers the time for other duties," she says.

In her department, each extender worked with case managers on approximately four units and was responsible for about 60 to 80 patients. They were responsible for finding out if patients and families had a preference of a post-acute provider and/or helping them choose one.

"Once a patient was ready for discharge, the case manager informed the case management extender who uses the department's discharge planning software to gather information on the patient and transmit it to the providers the patient has chosen," Babina says.

The case management extenders collaborated with nursing, case management, social work, physical therapy, and occupational therapy to meet patient needs, she says. They worked with nursing to make sure that the discharge planning paperwork, including physician orders, were complete and that the transcription was done in a timely manner, she says.

Case management extenders don't necessarily need a college degree but some experience in a health care setting is helpful, Babina says. "It helps if they are familiar with medical language," she adds.

Extenders should be able to work under stress in a fast-paced environment. They should be computer-literate, articulate, and make a good impression, Babina says.

"We found case management extenders to be extremely helpful. They established a relationship with the case managers to which they were assigned and with the providers and resources in the community. As they were discharge-savvy, they became the right hand of the department and made a good workflow even better," she says. ■

CM-physician alignment cuts length of stay

Enhanced communication is the key

The average length of stay for patients with pneumonia, sepsis, and heart failure dropped by one day when a care coordinator was assigned to a hospitalist group and followed its patients throughout the hospital stay during a pilot project at Sentara Princess Anne Hospital in Virginia Beach, VA.

"While this is just one of the strategies we utilized for length-of-stay management, the ability to have concurrent reports and ongoing physician communication has made a huge difference," says **Teresa Gonzalvo**, RN, BSN, MPH, CPHQ, ACM, vice president for care coordination for Sentara Healthcare, with headquarters in Norfolk, VA.

Based on the success of the pilot, the health system has rolled out the model on Sentara Princess Anne's medical-surgical and step-down units. The care coordinators are working with three physicians who are part of Sentara Medical Group

and Bayview Medical Group, she adds.

The health system is moving toward rolling out the model in the other seven hospitals, she adds.

Sentara's unit-based/dyad model of care coordination assigns care coordinators and social workers by geography. In that model, when patients are transferred to a different unit, their care is coordinated by a different set of care coordinators and social workers, Gonzalvo says.

"With the focus on patient-centric strategies, heightened awareness of value-based purchasing and other healthcare reform initiatives, the health system created a high-performance design team with the goal of determining ways to better manage patient transitions across the continuum," Gonzalvo says.

The team decided to try a hybrid pilot project that aligns care coordinators and physicians, she adds.

"The model aligns with the system goal of being more patient-centered and communicating more effectively with the patient, family members, and other healthcare providers across the continuum of care," says **Pat Vajda**, RN, BSN, CCM, manager for care coordination at Sentara Princess Anne.

The pilot project at Sentara Princess Anne Hospital assigned one care coordinator to a group of two to three hospitalists with a caseload of 20 to 23 patients. When the caseload got higher, another care coordinator was assigned to help out.

"We couldn't include 100% of patients, so we concentrated on the three clinical conditions where there was a lot of opportunity—pneumonia, sepsis, and heart failure. The care coordinators assess every patient and focus on the patients who need services," Gonzalvo says.

After the success of the pilot, the team developed a business plan to replicate the model throughout the health system, Gonzalvo says.

When developing the business plan, the team looked at the volume of patients that the care coordinator was able to impact. "We looked at patients who were risk-stratified based on the three targeted diagnoses plus readmitted patients, those with complex conditions or comorbidities, those who were frequently admitted or those with social issues. We are concentrating on those at high risk," she says.

The ultimate goal is to assign each care coordinator to one physician supporting the individual hospitalists' patients. The social workers will remain unit-based, Gonzalvo says.

"It's a hybrid model. We are starting slowly. The care coordinators and physicians are not aligned throughout the hospital system yet, but we are getting there," she says.

The result is a more patient-centered model, she says. The care coordinator follows the patients wherever they go while they are in the hospital.

"While traveling through the hospital can be an issue, the use of technology, the electronic medical record and our case management application, are critical success factors and major drivers for efficient and effective workflows," Gonzalvo says. The case managers use workstations on wheels at one hospital. The health system has plans to install these at other hospitals when the capital budget is approved, she says.

"The care coordinator becomes a familiar face to the patient and family member," she says.

The arrangement has led to enhanced communication between the hospitalists and the care coordinators, resulting in better care for patients and improved throughput, says **Albert I. Soriano**, MD, FACHE, co-clinical chief of hospital medicine at Sentara Princess Anne.

"In the past, we typically worked with more than one care coordinator. Now, the hospitalists

EXECUTIVE SUMMARY

When Sentara Healthcare enacted a pilot project in which a care coordinator was assigned to a hospitalist group and followed patients throughout the hospital stay, the average length of stay for patients in the program dropped by one day.

- One care coordinator was assigned to two to three hospitalists and had a caseload of 20 to 23 patients with pneumonia, sepsis, or heart failure and other patients determined to be at high risk.
- Care coordinators meet with hospitalists each morning to review patients likely to be discharged that day, meet again during multidisciplinary rounds, and communicate constantly during the day.
- Other initiatives include providing box lunches for patients discharged around noon and establishing a team of discharge facilitators in a central location to send referrals to post-acute providers and set up transportation.

have a close working relationship with the care coordinator assigned to them. There's always a proactive conversation about where patients are going after discharge and what their needs will be, and that's what's driven the length of stay down," Soriano adds.

When they arrive in the morning, the care coordinators review the charts of patients in the hospital, set priorities, and come up with the plan for the day. "They look at the patients who were scheduled for discharge but are still in house and see what occurred to keep them in the hospital," Gonzalvo says.

The care coordinators meet with the hospitalists to whom they are assigned each morning and review the patients likely to be discharged that day or the following day and determine what needs to happen to expedite the discharge, Soriano says. They meet again during multidisciplinary rounds that include nursing, pharmacy and representatives from other ancillary departments and review all the patients on the floor and discuss transition plans for the next day as they evolve.

"We are in constant communication as the day progresses. I may walk into a room and find that the patient is better than I expected. Then I'll call the care coordinator on the phone and tell her that Mr. Smith is ready to go home. She can start taking care of his discharge needs right then and there," he says.

In the past, physicians would write the order for discharge on the chart but it might be hours before someone saw it. "During that time, somebody could have been ordering durable medical equipment, or ordering transportation. Being in constant communication expedites things tremendously," Soriano says.

To further expedite discharge, the hospital has arranged for dietary to have box lunches available if the patient is discharged around lunch time, Gonzalvo says.

In addition, a team of discharge facilitators in a centralized location sends referrals to post-acute providers and schedules transportation ahead of time. The arrangement allows care coordinators and social workers to spend more time with patients, families, and physicians, instead of being bogged down with administrative tasks, she adds.

> "THERE'S ALWAYS A PROACTIVE CONVERSATION ABOUT WHERE PATIENTS ARE GOING AFTER DISCHARGE..."

"We have made a concerted effort to look at avoidable days and troubleshoot to avoid them," she says. For instance, if the physician has ordered a consultation that hasn't taken place, the care coordinator gets in touch with the consultant and determines what has happened.

"The same hospitalist-care coordinator team works together all the time. Everybody knows everybody, and they communicate well. They all have the same goals. When the care coordinator at Princess Anne took a few days off, the hospitalists all said they missed her," she says.

When patients are admitted, the care coordinators perform an initial assessment within the first business day and develop a transition plan and length-of-stay target.

If patients are not able to be transitioned after the estimated length of stay, the care coordinator analyzes why. If it was a true avoidable delay, such as services were not available over the weekend, the care coordinator documents it. The avoidable delays, and ways to avoid them, are discussed with the hospitalists and at multidisciplinary rounds, Gonzalvo says.

When patients are readmitted, the care coordinators perform a readmission assessment along with the initial assessment. "We are trying to get information up front as we move forward with transition planning and preventing readmissions," she says.

The entire care coordination leadership team receives weekly reports on avoidable delays, daily census, discharge dispositions to skilled nursing facilities and home care agencies, as well as readmissions, Gonzalvo says.

The Hampton Roads Long-Term Care Council, composed of community and Sentara post-acute providers, works collaboratively on care transitions. In addition, the hospital's Utilization Management Committee meets monthly and discusses trends in transitions and readmissions.

"Patient-focused communication, information management, teamwork, resource management, and post-hospital transition planning all contribute to our successful care coordination initiative," Gonzalvo says. ■

An extra day in the hospital may prevent readmissions, reduce mortality

Longer LOS gives patients time to recuperate, according to study

With penalties rising for hospitals with high readmission rates, the solution may be to keep patients a day longer, researchers at Columbia Business School concluded.

"Given the stiff penalties imposed under the Affordable Care Act, hospitals are implementing a variety of approaches to aggressively reduce readmission rates, most commonly involving outpatient care," says **Ann P. Bartel**, BA, MA, PhD, professor of finance and economics at Columbia Business School.

"While some types of outpatient interventions can be effective, our study shows that hospitals should consider keeping some of their patients in the hospital longer to reduce readmissions and mortality," she adds.

Bartel worked on the project with Carri Chan, PhD, associate professor of decision, risk and operations at Columbia Business School, and Hailey Kim, PhD, postdoctoral associate in operations management at Yale's School of Management.

The researchers reviewed the charts of more than 6.6 million Medicare patients who were hospitalized for pneumonia, heart failure, or heart attack from 2008 to 2011 to determine how long they were in the hospital. "We took into account any other conditions patients had at the time of admission, their age, gender, and other factors," she says.

The three researchers concluded that one more day in the hospital decreases the risk of readmissions by 7% for heart failure patients with high severity. The researchers did not find a relationship between readmissions and length of stay for pneumonia and acute myocardial infarction patients, but the research did show that a longer length of stay can reduce mortality risks by 22% for pneumonia patients and 7% for heart attack patients, Bartel says.

"Some factors that cause readmissions are out of the control of the hospital. But there are things that hospitals can do to reduce readmissions, and one is to keep patients an extra day," she says.

Many hospitals try to reduce readmissions using outpatient management and having a nurse or another person follow up to make sure patients are taking their medication and following their treatment plan, but that might not be the most cost-effective way, Bartel points out.

"We analyzed the existing data to determine if it would make more sense from a cost-effective standpoint to keep patients one extra day rather than use outpatient management. We concluded that, depending on the actual costs of both options, keeping patients an extra day could be more cost-effective than the outpatient management programs currently in place," she says.

The researchers determined that for heart failure patients, the inpatient and outpatient interventions have almost identical impact in reducing readmissions. But with heart attack and pneumonia patients, extending the length of stay by one day can potentially save five to six times as many lives as an outpatient program.

The extra day may allow patients to reach a higher level of stability as well as providing more time for the staff to educate the patients on their post-discharge care plan, Bartel says.

In addition, the team concluded that patients who were admitted on a Sunday or Monday typically had a shorter length of stay than those who were admitted on a Tuesday, Wednesday, or Thursday. "If patients are approaching the last day of their stay and it bumps up against the weekend, they are more likely to be discharged prematurely and more likely to be readmitted within 30 days," Bartel says.

For more information, visit http://www.columbia.edu/~cc3179/medicare_2014.pdf ■

EXECUTIVE SUMMARY

When researchers at Columbia Business School reviewed Medicare records, they concluded that an extra day in the hospital decreases the readmission rate and mortality risk for some patients.

- They examined the charts of more than 6.6 million Medicare patients who were hospitalized for pneumonia, heart failure, or heart attack.
- They concluded that one more day in the hospital cuts the risk of readmission for heart failure patients by 7%.
- The extra day lowered the mortality rate for pneumonia and heart attack patients.

Hospital's wellness program cuts health care costs by more than $5 million in five years

Key action: Linking employee health to health care benefits

At the place where employee health and hospital benefits and wellness programs intersect, some striking results can be achieved. For JFK Health in Edison, NJ, an employee wellness program, fueled by individual and group biometric data, has resulted in these encouraging outcomes:

- 31% decrease in hospital admissions among employees and their families;
- 50% decrease in hospital readmissions;
- 48% higher cancer screening compliance than the national average;
- 35% higher diabetes disease management than the national average;
- $2.8 million in benefit savings returned to employees in 2013, and more than $5 million in health care cost savings over the past five years.

"Back in 2006-2007, we initiated our wellness initiative within our health system," says **Pat Cooke**, corporate director for human resources for JFK Health. Cooke's roles include some employee health services.

Hospitals should start with some sort of wellness program as a building block to achieving employee population health improvements, she suggests.

"We started with an employee wellness team, identifying what our vision was for wellness and the three main strategies we were trying to accomplish," Cooke says. "Our vision was to help employees lead healthier lives, to build awareness, and to get employees involved in our education, awareness, and wellness activities."

Another goal was to create a workplace atmosphere that reflects wellness and chronic disease prevention.

The hospital started by promoting walking and stairclimbing. They put inspirational posters on stairwells throughout the hospital.

"We used posters that showed someone running and not giving up," Cooke says. "We painted the hospital staircases and made them bright, trying to encourage people to take the stairs."

Then the hospital added some healthy snacks to the vending machines.

"The biggest thing we did was create a passport to wellness, rewarding employees for getting health screenings," she says.

Linking employee health to health care benefits

These efforts raised awareness and created a foundation that made employees aware of the hospital's focus on healthy behavior, but they didn't result in significant population health improvement until a third component was added: a health care benefit program that provided financial incentives for positive health actions.

The hospital teamed up with San Francisco-based SeeChange Health to unite employee health and wellness into JFK Health's benefit plan.

"The trick is to engage employees continuously and in a sustainable manner over a long period of time," says **Jon Watson**, senior vice president of operations at SeeChange Health.

"There's a dynamic that has changed," Watson adds. "We measure and look at data and see how employees' behavior affects the hospital across the health care continuum."

The more buy-in a health system achieves from employees, the more engaged employees are and the better the results.

"We started a Healthy Plus Plan," Cooke says. "There are six different benefit plans for employees, and three of these are Healthy Plus Plans."

When an employee selects the Healthy Plus Plan, he or she is committed to doing health screenings and taking preventive care actions. In return, the employee receives lower employer health care contributions and other rewards that the hospital provides, such as taking a half day off to get wellness screening and lower co-pays for prescription drugs, Cooke explains.

One incentive is extra life insurance: "It doesn't cost us a lot, and they appreciated it," she says.

"We rolled this out, and it's perfectly voluntary, but if they choose the Healthy Plus Plan, they have to do the cancer screening: PAP smears, mammographies, PSAs, and colon-rectal, which only 20% to 25% of employees were doing," she adds.

Only one in four employees participated in the Healthy Plus Plan at first, but that has grown over the past few years to 82% of employees.

The last piece to the employee wellness puzzle was to obtain biometric screenings of employees. These include body-mass index, blood glucose levels, blood pressure, nicotine and cholesterol levels.

"We told employees they could earn additional rewards based on goals we set up related to these results, so our program's progression is moving from efforts to results," Cooke says.

All of these population health efforts are a growing trend thanks to the accountable care organization model of the Affordable Care Act, she notes.

"Our employee benefit plan was doing population health before population health became cool," Cooke says.

The hospital's wellness team continues to focus on traditional employee health issues like slips, trips, and falls through education and exercise physiology and on employee stress reduction. But it's in the wellness side — following the collection of biometrics — that the most impressive results have occurred.

"We tell employees that they have lost two carloads of weight," Cooke says. "We communicate their wellness results in a way that employees can understand." ■

Centers for Disease Control and Prevention panel cites lack of evidence for Tdap booster

Vaccination rates remain low for single dose

Health care workers who receive the pertussis vaccine do not need additional boosters, a federal advisory panel decided.

Outbreaks of pertussis in some states have raised concerns about the potential for hospital-based transmission. Only 31% of health care workers have been vaccinated with Tdap, according to data from the National Health Interview Survey, although the Centers for Disease Control and Prevention has recommended the one-time vaccine since 2006.

Studies show that Tdap's effectiveness wanes significantly within three years after vaccination. However, vaccinated individuals are less likely to develop symptoms and transmit the disease, epidemiologist **Jennifer Liang**, DVM, MPVM, told the CDC's Advisory Committee on Immunization Practices.

CDC continues to recommend post-exposure prophylaxis for health care workers who are exposed to pertussis, particularly those who care for high-risk patients, such as pregnant women and newborns. Health care workers who do not care for high-risk patients may be monitored for symptoms for 21 days, Liang said.

Rather than backing a booster vaccine to increase immunoprotection, CDC called for better coverage of health care workers with the single dose of Tdap.

"There is no evidence that additional doses would be preventive," Liang said.

Because Tdap coverage is low among health care workers, and the duration of protection afforded is unknown, post-exposure antibiotic prophylaxis is indicated for vaccinated workers in contact with patients at risk for severe pertussis infections (e.g. hospitalized neonates).

Recommended post-exposure drugs for exposed workers include azithromycin, clarithroymycin, or erythromycin. ■

Hospital Report Blog

For further analysis and discussion of topics important to hospital professionals, check out **Hospital Report**, AHC Media's award-winning free blog at http://hospital report.blogs.ahcmedia.com/. *Hospital Case Management*'s executive editor Russ Underwood and associate managing editor Jill Drachenberg both contribute.

COMING IN FUTURE MONTHS

- What's up with the Recovery Audit program?
- Choosing inpatient versus observation.
- Case managers and the revenue cycle.
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HOSPITAL
CASE MANAGEMENT

CNE INSTRUCTIONS

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CNE QUESTIONS

What ratio of case manager to patient does Beverly Cunningham, RN, MS, recommend if the case managers are doing utilization review, basic discharge planning, and care coordination and seeing every patient?

A. 1 to 10.
B. 1 to 15.
C. 1 to 20.
D. 1 to 25.

2. According to Christine Babina, RN, BSN, when case managers do a time study, how often should they document what they are doing?

A. Constantly.
B. At the end of the shift.
C. Every 15 minutes.
D. Every half hour.

3. According to BK Kizziar, RN-BC, CCM, many case managers spend time copying charts, filing, faxing, phoning, stapling, and writing reports — tasks that take a lot of time but are not a part of the actual case management process.

A. True
B. False

4. In a pilot project at Sentara Princess Anne Hospital that assigned one care coordinator to a group of two to three hospitalists, what was the caseload of the care coordinator?

A. 15 to 20 patients.
B. 20 to 23 patients.
C. 22 to 25 patients.
D. 30 patients.

CNE OBJECTIVES

After reading each issue of Hospital Case Management, the nurse will be able to do the following:

1. identify the particular clinical, administrative or regulatory issues related to the profession of case management
2. describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the healthcare industry at large
3. discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.