HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Focus on patient safety all day, every day

A big part of your job is keeping patients safe

You may think that because you're a case manager, you aren't directly involved in patient safety. You couldn't be further from the truth, experts say.

"Case managers may not think of themselves as a patient safety officer, but a lot of what they do is part of patient safety. Case managers promote patient safety through ensuring a safe discharge, improving outcomes, and preventing unnecessary readmissions," says **Sue Dill Calloway**, RN, MSN, JD, CPHRM, CCM, CCP, president of Patient Safety Education and Consulting in Dublin, OH.

Case managers are another pair of eyes in the system, adds **Patrice Spath**,

EXECUTIVE SUMMARY

Case managers may think their job doesn't involve patient safety, but they promote safety by ensuring a safe discharge and are in a position to see safety breaches and mistakes all over the hospital.

- CMS includes discharge planning in its worksheets for surveyors to use to assess a hospital's compliance with Medicare Conditions of Participation.
- Because they work with patients from admission to discharge, case managers know which clinicians are competent, those who are not, and may observe safety breaches like failure to wash hands and leaving the catheter in too long.
- Case managers should spend enough time with their patients to know their situations at home and their support systems and use the information to create workable and safe discharge plans.
- Hospitals should create an environment and a culture where case managers and other clinicians feel comfortable speaking up when they see safety breaches.

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RHIT, principal in Brown-Spath & Associates, a Forest Glen, OR healthcare quality consulting firm. "As they move throughout the hospital, they see what's going on and can act as a safeguard by identifying patient safety breaches and potential mistakes," Spath says. *(For more on what you can do when you see a safety breach, see related article on page 68.)*

"If there is anyone on the healthcare team who has a wide-angle view of what is going on with patients, it's the case manager. The case manager's perspective is extremely valuable because they watch over patients from admission to discharge. Any case manager who works in a hospital for any amount of time knows where the strengths and the weaknesses are," adds **John D. Banja**, PhD, professor, department of rehabilitation at Emory University in Atlanta and a medical ethicist at Emory's Center for Ethics.

The Centers for Medicare & Medicaid Services (CMS) is placing a lot of emphasis on patient safety, Spath points out. "Patient safety issues have financial implications for hospitals, but they also affect patient satisfaction. Studies have shown that patients who feel safer are more satisfied with their hospital experience," she says.

Discharge planning is the topic of one of the three worksheets CMS developed for state and federal surveyors to use when they assess hospitals' compliance with the Medicare Conditions of Participation, Dill Calloway says. The other two worksheets focus on infection control and performance improvement.

"It's easy to see that infection control and performance improvement are a part of patient safety, but discharge planning may not fit into everyone's idea of patient safety," she says.

However, if a patient who is discharged from the hospital doesn't know how to take care of his or her surgical wound and ends up with an infection that requires hospitalization, it's a patient safety issue, she points out.

"Healthcare is a very complex system being run by well-meaning but imperfect human beings. The opportunity for disaster is always there in the hospital. It's a very dynamic and complex environment that always runs imperfectly," Banja says.

"Very few catastrophes are caused by a single person doing something stupid. They occur when multiple people make multiple mistakes and they all glom together. The road to patient safety is to be able to see errors and halt their potential for disaster before they cause harm," he adds.

Case managers have the opportunity to see how everyone on the staff relates to or interfaces with patients, Banja says. "They know which healthcare professionals are competent, and when the system is working well. They also know people who take shortcuts and engage in other behavior that could harm patients. They know because they are in a position to observe what is going on and they should be constantly concerned about maintaining a safe environment," he says.

The Affordable Care Act and the shift to pay for performance bring a heightened awareness of patient safety and the role that case managers play, says **Patrice Sminkey**, RN, chief executive officer for the Commission for Case Management Certification.

"Case managers have the opportunity to engage the

healthcare team, the patient, and his or her support system to ensure that patients are safe in the hospital and have a safe discharge and transition," she says.

As they work with patients, case managers should involve patients and family members in hospital safety issues, Spath says.

Case managers can help patients and family members recognize red flags that may indicate a safety concern and speak up about them, she advises. For instance, encourage them to say something to the nurse if the medication for the patient looks different or if the patient seems to be getting worse, she says.

Case managers also should be on the lookout for red flags indicating that a patient is at risk, Spath says. "For instance, failure to progress is a particularly problematic area that generates a lot of litigation. Often when there is a sentinel event, it is because of failure to notice that the pain is not well controlled or that the patient is not getting better. The case manager is another person who should be watching for red flags that indicate the patient is not responding to treatment," she says.

One of the most common hospital-acquired conditions is catheter-associated urinary tract infections, Spath points out. Case managers should mention it to staff if it appears from the medical record that the catheter has been in too long, she adds.

Case managers should also intervene in cases of domestic violence, suspected child abuse, and elder abuse, Dill Calloway says. "Case managers have the resources to get child services or elder services involved or arrange a safe house for families. Ensuring that patients have a safe place to go back to is another facet of patient safety," she says.

A lot of what case managers are doing to keep patients from being readmitted falls under patient safety and that starts with a thorough assessment, Sminkey says.

Case managers should complete a solid assessment and be keenly aware of what the patient needs after discharge, Sminkey says.

"Knowing patient needs and potential risks up front helps the hospital staff make sure the patient is safe and allows us to improve the transition when the patient moves to another setting," she says.

> "HEALTHCARE IS A VERY COMPLEX SYSTEM BEING RUN BY WELL-MEANING BUT IMPERFECT HUMAN BEINGS. THE OPPORTUNITY FOR DISASTER IS ALWAYS THERE IN THE HOSPITAL."

Even though the patient assessment often calls for documentation by checking off boxes, it can't be a replacement for assessing the whole person, including psychosocial and emotional needs, Sminkey says.

Spend time with your patients and find out everything you can about their family dynamics, their home environment, and their support system. Ask the patients what kind of place they live in, if there are stairs and how many. Ask if they can cook their own meals and if they feel comfortable taking a shower without assistance, Dill Calloway suggests.

Include the need for home modifications in your assessment, Dill Calloway says. For instance, if someone has limited mobility, ask about the stairs in his or her home. Does the family need to have a wheelchair ramp installed?

Case managers should be aware of the patient's risk for falls and reinforce the fall prevention instructions, Spath says. "Case managers often spend more time talking with the patient and family than the nurse. If they feel the risk for falls is higher than the record indicates, they should speak up," she says.

"Patients are at higher risk for an adverse event when they move from one setting to another and it's up to case managers to ensure a safe transition," Sminkey says.

Start by identifying patients who need a discharge evaluation, Dill Calloway says, adding that the CMS surveyor worksheets look at whether case managers make their patients aware that they can request a discharge evaluation and that their physician can request one, she says.

"During the hospital stay, case managers should assess and reassess patients for discharge needs. It's not sufficient just to come in and spend five minutes going over a checklist," Dill Calloway says. *(For a look at two discharge plans with different outcomes, see page 69.)*

Consider the whole person and his or her support system when you create a discharge plan, Sminkey says. "When case managers educate the patient, they should know who else to engage in the process. It may not be the family. It could be a neighbor or someone else in the community," she says. ■

Part of patient advocacy is reporting errors

Case managers can speak up about safety breaches

Hospital case managers are in a prime position to see many things that consistently go wrong or need improvement but, like everyone else, may be reluctant to bring them up, says **John D. Banja**, PhD, professor, department of rehabilitation at Emory University in Atlanta, and a medical ethicist at Emory's Center for Ethics.

Based on his experience, Banja has come up with four reasons why health professionals don't speak up even when they know the system is not working properly.

- They fear retaliation.
- They don't know how.
- They believe the leadership will not be responsive.
- They believe it's not their job.

But, as advocates for their patients, hospital case managers have an obligation to speak up whenever they see a safety breach, adds **Patrice Sminkey**, RN, chief executive officer for the Commission for Case Management Certification.

"If you don't speak up, the person who made an error may do it again. When case managers see a breach, they should make it a teachable moment and take the opportunity to educate the person making the mistake," she says.

For instance, if a staff members fails to wash his or her hands before seeing a patient, say something like, "This is a gentle reminder that hand washing is a must. Most infections are spread through poor hand washing," Sminkey suggests.

How involved case managers can be in patient safety depends on how the organization views the case management role, says **Patrice Spath**, RHIT, principal in Brown-Spath & Associates, a Forest Glen, OR, healthcare quality consulting firm. "If case managers are just viewed as someone who arranges post-discharge services and calls the health plan, they are less apt to be engaged in safeguarding the patient. Ideally, the organization sees case managers as another member of the clinical team and they are listened to when they question what is going on with a patient," she says.

> "THE FACT IS WE LARGELY CAN'T PREVENT ERRORS UNLESS WE REPLACE HUMANS WITH MACHINES."

Poor hand hygiene may well be the No. 1 patient safety breach in the healthcare arena, Banja says. Failure to check patient arm bands, not gowning up appropriately, not performing safety checks, violating policies on storing and dispensing medications (like failing to review the Five Rs — Right patient; Right drug; Right dose; Right time; Right route — when giving medication) are also significant problems, Banja adds.

Hospital staff should be encouraged to speak up when they see a safety breach, he says. "It's always better to nip the problem in the bud. The longer we let people go when they are doing the wrong thing, the more entrenched the deviation will become," Banja says.

Healthcare professionals who are "in the trenches" often deviate from rules and regulations they find counterintuitive and that interfere with their productivity targets, Banja says. "One of the hard things about healthcare is that it is almost impossible to comply with all the procedures and policies," he says.

"The fact is we largely can't prevent errors unless we replace humans with machines. But we can prevent many disasters if health professionals would be more aggressive and courageous in attending to system weaknesses, including compliance with rules and standards," he adds.

One of the greatest challenges healthcare leaders face is to cultivate a non-punitive and blameless environment so that the staff know how to respond to a physician or a nurse who is not working according to expectations or professional standards, Banja says.

"Leadership has to cultivate an environment where people feel safe speaking up about issues that threaten patient safety without fear of retaliation," he says.

Most hospitals have a formal system of reporting incidents, Banja says. "But hospitals are a very social environment. People work closely together and it often feels like a family. You can have all the formal incident reporting systems in place but if someone feels the person who made the error will retaliate, many people won't report it," he says.

"The challenge is to create an atmosphere of safety and respect whereby all healthcare personnel can speak up in a constructive and patient-centered way," Banja says. ■

A tale of two discharge plans

Poor planning leads to safety issues

Sue Dill Calloway, RN, MSN, JD, CPHRM, CCM, CCP, president of Patient Safety Education and Consulting in Dublin, OH, relates two stories from real life to illustrate how discharge planning is closely aligned with patient safety.

Several years ago, Dill Calloway's mother, who was 85 at the time, was admitted to the hospital after she went to the emergency department complaining of chest pain. She received a CT scan, was placed on a cardiac monitor, and admitted. After several days, the admitting physician concluded that she was having chest wall pain.

"Her family physician had discontinued her non-steroidal anti-inflammatory medication which was causing the chest wall pain," Dill Calloway says. Dill Calloway was out of town and asked her sister, who was at the hospital, to make sure she was discharged with a prescription for an anti-inflammatory medication.

The attending physician instructed the family to call the primary care physician for an appointment and to get the prescription then. The case manager did not intervene. Her primary care appointment was scheduled for two days after discharge but in a day-and-a-half, she was back in the hospital with a blood clot.

"Without the anti-inflammatory medication, my mother was in too much pain to move. She stayed in bed with the heating pad and developed the pulmonary embolism. This became a patient safety issue caused by poor discharge planning," she says.

In contrast, a few months ago, Dill Calloway's mother was hospitalized after a serious automobile accident. When she no longer met inpatient criteria, she still could barely walk. The discharge planner arranged for a stay in a rehabilitation facility.

"The discharge planner made sure they were meeting her needs after discharge. She could barely walk with a walker when she went to rehab. If they had just sent her home, even with home health visits, she could have fallen and been readmitted or even died. This is an example of how good discharge planning promotes patient safety," Dill Calloway says. ■

Patient status reviews are on hold again

Congress extends Probe and Educate

Patient status reviews by the Recovery Auditors have been delayed again, this time until Oct. 1, 2015, by an act of Congress.

When Congress passed legislation that eliminated the Medicare sustainable growth rate payment for physicians, it also postponed full implementation of the Centers for Medicare & Medicaid Services' controversial "two-midnight" rule and extended the Probe and Educate audit program through Sept. 30, 2015, according to **Kurt Hopfensperger**, MD, JD, senior medical director of audit, compliance, and education at Executive Health Resources, a Newtown Square, PA, healthcare consulting firm.

CMS had already changed the proposed start of the Recovery Auditors' inpatient status review audits until April 30 in anticipation that Congress would include the issue in the sustainable growth rate bill as it did last year. As part of a 2014 bill addressing the sustainable growth rate, Congress delayed enforcement of the two-midnight policy through March 31, 2015, and prohibited the Recovery Auditors from conducting post-payment reviews of claims that fall under the two-midnight rule.

CMS began the Probe and Educate initiative — pre-payment audits by the Medicare Administrative Contractors (MAC) — to help hospitals understand the two-midnight rule implemented in the 2014 Inpatient Prospective Payment System (IPPS) final rule. At the same time, CMS prohibited the Recovery Auditors (RAs) from conducting inpatient status review audits with dates of admission through the Probe and Educate period.

The bill passed by Congress doesn't include specifics about the Probe and Educate initiative, Hopfensperger points out. However, CMS limited the MACs to three rounds of audits on each hospital. "Unless CMS directs the MACs to perform a fourth round of audits, hospitals can expect the MACs to stop after three Probe and Educate audits," he says.

The 2014 Congressional bill also directed CMS to develop a policy to address payment for the short-stay patients who receive inpatient services but do not need to be in the hospital over two midnights. CMS has asked for feedback on the issue, but has not announced a policy.

In the 2016 IPPS proposed rule, CMS stated that it is considering the feedback it has received and expects to have further discussions on the subject. *(For more on the IPPS, see the July issue of* Hospital Case Management*.)*

In early 2014, CMS announced plans to revamp the Recovery Audit program in response to industry feedback and issue new contracts with audits starting under the new program on January 1, 2015. The agency made changes to the program and started to rebid the Recovery Audit contracts. However, the process has been held up by a court order that directs CMS to rewrite the business portion of the new contracts to be in line with customary business practices, Hopfensperger says. Meanwhile, the new Recovery Audit program is on hold.

"It's unlikely that CMS will complete this and have the new Recovery Auditors in place by Oct. 1. The existing RAs will be conducting the patient status reviews under the existing rules if the reviews resume on Oct. 1," he adds. ■

Safety First initiative helps hospital cut safety events by 50%

Entire staff focuses on identifying, preventing errors

Since the Virginia Commonwealth University Medical Center began its Safety First Every Day initiative in 2008, the 1,125-bed health system has achieved a 50% reduction in serious safety events, an 83% decline in falls with injury, an 88% reduction in infections overall in intensive care units, and a 35% increase in safety occurrence reporting.

The hospital was awarded the American Hospital Association-McKesson Quest for Quality Prize for 2014 in recognition of its comprehensive patient safety and quality program.

"Patient safety is part of our culture. It's in the fabric of everything we do. We consistently stop and think about what we are doing and whether what we are setting up is safe," says **Ryan Raisig**, MHA, director of care coordination at the Richmond, VA, hospital.

Among the numerous patient safety initiatives are a four-hour safety training program for all employees, recognition of employees who report safety breaches, and an Early Warning System to alert clinicians when patients' conditions are deteriorated, he says.

The hospital has cut the rate of serious safety events and they continue to decline, says **Dale Harvey**, MS, RN, director of performance improvement. "We are constantly raising the bar to get better. Our goal is for all 14,000 team members to be looking out for patient safety issues and to intervene proactively," she adds.

The patient safety program was developed by a multidisciplinary team with guidance from experts in higher reliability science, Harvey says. "We completed a diagnostic assessment of our culture, what it was like then and what we wanted it to be. This included interviewing everyone from physicians and frontline staff to executive leaders and board members. Then we developed key strategies that include putting safety first on every agenda, a daily safety check-in, and discussing safety at every meeting," she says.

Working with high reliability experts, the team developed a four-hour safety training program called Behavior Expectation for Error Prevention (BEEP) that focuses on incorporating safety awareness into every staff member's work day.

The program includes teaching employees, called team members, how the brain functions so they can understand human fallibility, Harvey says. "We teach behavior that helps minimize mistakes and changes the way people think. Instead of blaming someone when things go wrong, we look at how to improve the system," she says.

The BEEP program aims to teach all team members safe behaviors such as paying attention to details and using the STAR (Stop, Think, Act, Review) approach to prevent things from going wrong. "These are simple tools but they are practical and easy to use in everyday work," Harvey says.

As part of its efforts to create a culture where people can talk about errors without assigning blame, the team started with stories of safety

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

The Top Ten Mistakes You May Be Making In Your Case Management Department!: Part 1

By Toni Cesta, PhD, RN, FAAN

Introduction

Case management has been in hospitals for 30 years now! In the grand scheme of things, this isn't a long time span. Despite our short longevity in the acute care setting, our roots go back to the 1920s and 30s as a community-based model for managing care for the poor. After health care reimbursement shifted to prospective payment in the mid-1980s, the need to coordinate care in the acute care setting became real and obvious. Or was it that obvious? While some hospitals across the country were early adopters of hospital-based case management, the majority lagged for years. In fact, 30 years later, some are still trying to figure out what this all means to them and to their bottom line!

THE BIG QUESTION LOOMING OUT THERE IS, "WHAT IS THE RIGHT MODEL FOR MY ORGANIZATION?"

Case Management in Your Hospital

While case management was evolving and changing in hospitals, the growing pains were apparent. Models, staffing ratios, reporting structures and outcome measures were variable and untested. Many hospitals still relied on the "utilization review" framework as the main structure with little focus on the integration of social work or the notion of coordination and facilitation of care. Some even went so far as to rename the department "case management" while actually changing very little else. This accompanied some bad decisions and some less than prudent ones. Some of you may still be living with some of these decisions in your hospitals today. You may be a director trying to "update" or re-engineer the department, but aren't getting the administrative support you need. You may be a case manager who is drowning in paperwork, has too many patients to adequately handle, or is "putting out fires" all day.

Previously, we talked about how to get the case management message to the executive suite. This month, we will talk about the top mistakes that hospitals are making in terms of their case management department's structure, processes, and outcome measures. The big question looming out there is: "What is the right model for my organization?" Unfortunately, there is no one answer to this question. The answer lies in each hospital's needs, infrastructure and budget. However, there are some best practices now that we, as case management leaders and staff members, can embrace and adopt into our daily practice.

Case Management Department Mistake Number One: "Role Confusion or Who is Doing What?"

You may be wondering what I mean by "who is doing what?" This is probably the biggest mistake a case management department can make and has to do with something we call role blurring or role confusion. This means that the roles and functions of the staff members are undefined and blurry around the edges. Not only do the staff members themselves not know exactly what they are or are not supposed to do, neither do the other members of the interdisciplinary care team!

Most case management departments are staffed with social workers and registered nurses. These two professional

groups are highly educated and competent professionals, usually with years of knowledge and experience. Despite these facts, many hospitals simply don't use them to the "top of their license," and meld together the roles and functions in such a way that the skill sets of each discipline are under-utilized or not utilized at all. Asking social workers and registered nurses to perform the same roles and functions results in a devaluation of both professions, as well as less productive for the organization that has hired them. Do administrators think that nurses and social workers are the same in terms of education, license, and knowledge base? Or do they think that anyone can perform the functions associated with case management? The answer to both questions is probably yes. The hospital executive you are dealing with may truly not understand the differences between what a nurse case manager does and what a social worker does. Indeed, they may think that the two professions are interchangeable, but it is up to us to redefine our roles for them when this misunderstanding happens. Some of this misunderstanding comes from a lack of appreciation of the unique skill sets that each discipline brings to the table. We are unique and different in many ways!

Registered nurses are educated in the medical/clinical components of patient care. We are educated in anatomy, physiology, microbiology, and other sciences. In addition, we get some education in therapeutic communication, family dynamics, and similar topics such as patient education. The amount of education we get in communication and family dynamics may depend on the level of education we receive to become a registered nurse. We may enter our profession with an associate's degree, a bachelor's degree, or even a master's degree. We may or may not have been exposed to some of the topics related to patient care that extend beyond anatomy and physiology. This is why many hospitals are now requesting a minimum educational preparation and years of experience to become a case manager. It is no longer a "lesser" job that you take, but rather a more advanced job that requires a higher level of skill and knowledge. These skills and knowledge build on your basic licensure and educational training.

> "THE ONLY WAY TO BALANCE THE WORKLOAD IS TO BALANCE THE CASELOAD. THESE TWO ELEMENTS ARE DEPENDENT ON EACH OTHER..."

Social workers are educated in a systems approach to healthcare. They are educated in counseling, crisis intervention, and family dynamics. They are educated to see the patterns in what patients do as they relate to the home, the psychosocial environment in which they live, and their level of education and health knowledge. Social workers are focused on processes and in helping patients and their families to cope and care for themselves. Social workers may have some clinical knowledge of anatomy and physiology, but this is not where their strength lies. It lies in their ability to help patients manage life-altering events, trauma, crisis, and end of life. These skills require that social workers have the time to spend with their patients to listen to them, to counsel them, and to assist them through very difficult times and situations.

For decades, social workers had "owned" discharge planning. Social workers were the professional group that processed patients' placement in nursing homes and completed the paperwork for home care. They assisted patients in coping with these life changes. However, they were dependent on the clinical team to "feed" them the destination that the patient was going to. When lengths of stay were long and discharge planning less urgent, this approach was fine. However, prospective payment was a game changer. Changes in reimbursement required hospitals to manage their length of stay and resource consumption, and it also required utilization management and discharge planning to become closer and more integrated processes.

In addition, community resources became more robust. High-tech intravenous services and sub-acute levels of care, among others, required that a clinical eye be placed on the discharge planning process. This focus needed to happen in conjunction with the utilization management process, not apart from it.

So, what needed to change? The owner of the discharge planning process needed to move from the social worker to the nurse case manager. This shift frees social workers to perform the skills that they went to school for, such as counseling and crisis intervention.

They still needed to participate in the elements of discharge planning that required a more psychosocial focus such as long-term nursing home placements, hospice placements, or other discharge destinations requiring working with the patient and family in making hard or painful decisions. The nurse case manager could work on the elements of discharge planning that had a greater clinical element or focus such as home care, sub-acute or long-term acute care placement.

Ultimately, the purpose in all this was to clarify and outline the roles of each professional so that the nurse case manager and the social worker's skill sets could be optimized. This is better for the patients and families, for the organization, and for the professionals themselves.

Listed below is an example of how the work might be divided between the two disciplines:

RN Case Manager Roles:

- Patient flow or coordination and facilitation of care
- Utilization management
- Resource management
- Transitional planning
- Discharge planning — clinical focus
- Avoidable delay tracking

Social Worker Roles:

- Psychosocial counseling and interventions
- Discharge planning — psychosocial focus

By prospectively outlining the roles of each discipline, the case management needs of the patient are applied to the discipline most capable and educated to address them. The processes are clear and the roles are consistent for all patients.

Case Management Department Mistake Number Two: "Inadequate Staffing Ratios"

Once the case management department has determined its roles for the nurse case manager and the social worker, the next important area of clarification is the staffing ratio for each discipline. No department in any hospital can function adequately if the workload exceeds the staff member's capacity. The case management department is no different than the nursing department, the hospitalists, or the physical therapists. Even residents and interns have maximum caseloads. For some reason, case management has been slow to catch on to the fact that excessive caseloads result in poor outcomes for the patients and the organization. They result in dissatisfaction for the case management staff and personnel turnover. So this is mistake number two: giving the staff more work than they can effectively accomplish in the course of a work day.

The only way to balance the workload is to balance the caseload. These two elements are interdependent, as well as the roles applied to each discipline as we discussed above. When departments switched to case management, they often retained the staffing ratios that were used when case management was utilization review. Case managers were then expected to perform additional roles and functions with the caseloads they had before. These caseloads could be as high as 50 or 60 patients. While this may seem obviously impossible, many departments plowed on, resulting in their doing only the basic essentials for each patient. The job became task-oriented and many patients were overlooked in the process.

Is Your Department a Shell of Case Management?

All a case manager can do in this situation is complete as many clinical reviews as they can and complete as much paperwork as they can. This is not case management! It is a mere shell of what case management is and can be. In order to take on additional roles and the functions associated with them, the staffing has to be adjusted accordingly. Changes in staffing patterns can emerge slowly. Many administrators asked case management to prove their value by calculating their "return on investment." What they do not appreciate or understand was that case management is mandated by the Conditions of Participation of CMS (the Centers for Medicare & Medicaid Services). Therefore, they are a fundamental requirement of any hospital seeking reimbursement from Medicare or Medicaid. In addition, a reduction in length of stay, cost, or denials could not be achieved by the case management department alone. Every department and discipline in the hospital has a hand in these outcomes and a part to play in improving them. Constant reflection on the need for more staff sometimes works, but sometimes falls on deaf ears.

The good news is that we now have 30 years behind us as well as a much better understanding of

the roles of the case manager and the appropriate staffing ratios needed to support those roles. As said before, these staffing ratios are completely dependent on the roles each discipline is performing and how the division of labor is carried out. Ultimately, the appropriate staffing ratios for your department will require a thorough understanding of your department's model and the work to be performed. The example provided above is the gold standard in role clarification and is commonly known as the "integrated model." Because the integrated model is best practice, we will review the staffing ratios for this model.

Staffing for Best Practice in the Integrated Model

The integrated model requires all patients to be seen by a nurse case manager. For some patients considered "high risk," they may also be followed by a social worker. Based on the design and roles outlined for the nurse case manager and the social worker above, the tables at the bottom of the page indicate reccomended staffing ratios.

Differences in Staffing

To further clarify the differences between the RN Case Manager and the Social Worker assignments, the following descriptions can be used:

RN Case Manager: Assigned fifteen **fixed** beds that are consistent daily. Patients may be discharged from these beds and new admissions received into these beds over the course of a day of work.

Social Worker: Assigned up to seventeen patients based on high-risk referral criteria. These 17 patients may be located across more than one unit, depending on the size of the units. Approximately 30% of all inpatients will match with the high-risk social work referral criteria, and of these, 17 will be assigned to each social worker. In total, only 30% of all inpatients will be followed by both a social worker and a nurse case manager.

Summary

This month we have begun reviewing the top mistakes hospitals make within their case management department's infrastructure. As discussed, the biggest mistake is to not clearly and prospectively define the roles of the RN case manager and the social worker to optimize each discipline's skill sets. Associated with this mistake is to have inadequate patient ratios assigned to each discipline. These mistakes are related and when roles are not clearly defined, it becomes almost impossible to understand or advocate for appropriate staffing ratios. If it appears that nurses and social workers can all do the same things equally well, then the organization will likely choose to go with the professional group that will cost the organization the least amount of money. In the end, this logic is penny-wise and pound foolish. We do both disciplines a disservice when we don't apply their skill sets adequately and don't have each group functioning at the "top of their license!"

Next month, we will continue to discuss the top mistakes hospitals make in their acute care case management departments' design. We will discuss the use of clerical support staff, assessments, and days of coverage. ■

RN Case Manager

Unit Type	Case Manager to Bed Ratio
Medical – including sub-specialties e.g. Oncology, Cardiology	1:15
Neurology	1:15
Surgical – including sub-specialties e.g. Neurosurgery, Orthopedics	1:15
Intensive Care	1:20
Step-Down (Intermediate)	1:15
Pediatric	1:20
Obstetrics/Gynecology	1:20
Acute Rehab	1:15

Social Worker

Unit Type	Social Worker to Patient Ratio (Active Cases)
Medical – including sub-specialties e.g. Oncology, Cardiology	1:17
Neurology	1:17
Surgical – including sub-specialties e.g. Neurosurgery, Orthopedics	1:17
Intensive Care	1:17
Step-Down (Intermediate)	1:17
Pediatric	1:17
Obstetrics/Gynecology	1:17
Acute Rehab	1:17

breaches in other institutions, then moved to a discussion of errors in their own hospital.

"We worked to create a culture where people talk about errors without naming names and look for ways to avoid them. We're not focused on the individuals involved in safety breaches. This is about systems and processes and how we work together. That's really a key strategy for engaging people and helping them understand why an error occurred," she says.

During BEEP training, the staff learn to point out patient safety errors to the person making the error when they observe them, using another safe behavior called "cross-check," Harvey says.

"Reporting a safety breach after the fact using patient safety event reports isn't very useful when you have an opportunity to correct the error in the moment. Our team members cross-check each other routinely to ensure adherence to the highest safety and quality standards. We find that the vast majority of people are not making the error intentionally and thank their colleague for pointing it out," Harvey says.

To reinforce the importance of pointing out errors, the hospital developed the Safety Star program in 2008 to recognize front-line team members who find an error and work collaboratively to prevent it from happening again. The chief executive officer comes to the employee's work area and gives him or her a gold pin to wear. "This is an example of how we reinforce the behavior we want to see," Harvey says.

The hospital developed its own copyrighted performance management decision tree to help the management team distinguish between an unintended human error and a disregard for a safety practice.

"We want to balance individual accountability with organizational and system accountability and to protect people when they make unintended mistakes. It's the difference between doing the best thing you can under the circumstances, or knowing a safety process and intentionally ignoring it," she says.

For instance, if someone doesn't sanitize their hands before going into a patient room, it could be that they were in a hurry and forgot. Or it could be that they have not been educated on how to properly wash their hands, she says.

"We want to make sure that we are not going after the individual if the system hasn't taught them what they need to know," she says.

It's become part of the hospital culture to cross-check everything, Rasig says. "The idea of cross-checking has made its way into non-vital areas. For instance, we'll be talking about a meeting at 1:00 tomorrow and someone will ask to cross-check the time because her calendar said it was at 2:00," he says.

Harvey tells of an occasion when she was talking to a case manager outside Harvey's mother's room in an intensive care unit. "The nutrition care assistant approached with a lunch tray for my mother. The case manager stopped her and said 'let's cross-check and make sure she is supposed to eat.' It was OK, but it was a good thing for the case manager to do even though she was in the middle of an intense conversation with me. This shows me that safety behaviors have become such a part of how we do our work that they are reflexive," she says.

As part of their patient safety initiatives, the case management department developed a care transition bundle of 10 things that should happen for every patient. "We understand that the items will be different for a newborn and a transplant patient, for instance. But this is an innovative way to measure how often the items happen and make changes to ensure that every patient gets what they need," Rasig says.

The case management department is using the safety principles in their relationships with post-acute providers. "When something unexpected happens, like the patient is readmitted from a skilled nursing facility, or the home health services

EXECUTIVE SUMMARY

Virginia Commonwealth University Medical Center's Safety First Every Day initiative has resulted in a 50% reduction in serious safety events, declines in falls with injuries and infections in intensive care units, and an increase in safety occurrence reporting.

- All employees go through a four-hour safety training program that focuses on creating safety awareness all day, every day.
- Employees who report safety breaches and work to correct them receive a gold pin awarded by the hospital's chief executive officer, who presents the pin at the employee's work site.
- The hospital has developed an Early Warning System which combines clinical expertise and technology to identify patients whose condition is deteriorating before they become worse.

didn't show up, we do the same thing we do when there is an internal breach," he says.

A team from the hospital meets with leadership and anyone involved with the patient at the community provider. They analyze what happened, why it occurred, and look at ways to improve the system so the same problem won't occur in the future, he says.

"We tell them that the meeting isn't about whether somebody did something wrong. It's an attempt to identify trends and figure out if we could have done something different that would result in a better outcome. Sometimes the answer is 'yes' and sometimes, it's 'no,'" Rasig says.

The performance improvement team is heavily involved in the case management initiatives, he says. "They are taking the same principles and applying them across the board. The performance improvement makes sure we are doing things in a structured way and helps us learn from what is happening in the rest of the institution," he says. ■

System alerts clinicians when patients need interventions

Process combines clinical expertise, technology

Virginia Commonwealth University Medical Center has designed a process that combines clinical expertise with technology to detect subtle changes in patients' conditions and alerts the hospital's Rapid Response Team to intervene in real time before the patients get any worse.

The Early Warning System is embedded in in the medical center's electronic health record and uses real time clinical data to identify patients who might need additional interventions.

The computer program pulls data including vital signs, lab values, and other clinical information from the electronic records of patients and calculates an Early Warning score for each patient. The scores show up on a dashboard that ranks patients according to how sick they are.

"When we analyzed safety opportunities and areas where we could make improvement, we decided to leverage our technology to provide better care for our patients. A computer can detect subtle deterioration in patients based on clinical data before it becomes obvious to a clinician," says **Dale Harvey**, MS, RN, director of performance improvement.

For instance, patients who have infections are at risk for developing sepsis when the infection spreads throughout their body. "These patients may have a slow, subtle increase in heart rate, a decrease in blood pressure, and other subtle changes in vital signs. The system can pick these up much quicker than the human brain can and we can intervene before the condition worsens," she says.

Rapid Response

The hospital has a Rapid Response Team of clinicians on duty 24 hours a day, seven days a week. Their job is to respond to calls by other team members and clinicians who need assistance at the bedside. They also respond to calls from patients or family members. "The team sometimes provides nothing more than a second assessment, but they also can provide expert critical care and another set of hands if the patient is critical," she says.

The system alerts the hospital's Rapid Response Team to triage and visit the most critically ill patients before they get a call from a doctor or a nurse that the patient is in distress, she says.

"The Early Warning system gives the Rapid Response team a guide to proactively go out and work with patients. When the team is not being called, the Rapid Response Team nurses use the Early Warning scores as a guide to seeing patients who might need interventions the most," Harvey says.

The case management department is adapting the Early Warning approach of using data to guide human interactions, says **Ryan Raisig**, MHA, director of care coordination.

The department is building a tool into the medical record that will analyze patient data for risk of mortality or readmission after discharge. "This tool will help us most effectively allocate resources. We will be able to use the patient score to identify at-risk patients early in the stay and take steps to ensure a safe transition," he says. ■

Clinic visits, CM interventions fill gaps in care after discharge

At-risk patients referred for post-discharge services

At Torrance (CA) Memorial Medical Center, patients who are at risk for readmissions are referred to the health system's post-discharge Care Coordination Clinic for follow-up care and/or receive post-discharge care coordination services from an ambulatory care manager who may be an RN or a social worker.

Early in the hospital stay, the hospital's unit-based case managers administer a readmission assessment tool, based on the Project BOOST program[1] and adapted to the Torrance Memorial Health System's needs. Patients with two or more risk factors are referred to the Care Coordination Clinic. As soon as the hospital case managers know the expected date of discharge, they set the follow-up appointment for the patients to see a clinician within 72 hours of discharge, says **Carol Ecklund**, RN, MN, AOCN, director of medical management at Torrance Memorial Medical Center.

When patients visit the clinic, a physician or nurse practitioner reviews their plan of care, conducts medication reconciliation, and reinforces the education they received at discharge.

"Discharges are so stressed and hurried that the patient can't absorb all the information they receive. We fill in the inevitable gaps that occur. The clinic visit is like a second discharge day," says **Ujjwala S. Dheeriya**, MD, medical director for Supportive Care Services at the 446-bed hospital.

Patients who are seen at the clinic are followed in the community by case managers and social workers in the hospital's post-discharge Ambulatory Care Management program or are receiving home health services.

"Having a case manager and a home health nurse both following them is too much for the patient. If patients have home health services, that agency does the case management and if needed, hands the patients off to the case management when they are discharged from home health," Dheeriya says.

The care coordination team works closely with patients' primary care physicians and gets buy-in from the physicians before scheduling a clinic appointment.

"We communicate back and forth with the primary care physicians and specialists, if appropriate, and keep them in the loop. If they are receiving home health services, I keep the home health staff informed as well," Dheeriya says.

When patients come into the clinic, Dheeriya conducts a thorough review of the hospital stay, conducts medication reconciliation, and reviews the discharge instructions with the patient.

"We take a patient-centered approach and use motivational interviewing to include the patient and caregivers. If the patient's condition is complex and he or she does not have a coordinated plan, we set a follow-up appointment. Most patients go back to their primary care physician after one visit," she says.

The ambulatory case managers make about 80% of their contacts by telephone and make home visits when they feel the patient needs it. They may accompany the patients on their appointments at the Care Coordination Clinic. "Their job is to pick up the ball and make sure whatever care plan is developed in the hospital is followed as they transition back home and back to their primary

EXECUTIVE SUMMARY

At-risk patients who are being discharged from Torrance (CA) Memorial Medical Center are referred to the Care Coordination Clinic for follow-up care and/or receive care coordination services from an ambulatory care manager.

- At the Care Coordination Clinic, a physician or nurse practitioner reviews the discharge plan, reinforces discharge education, conducts medication reconciliation, and communicates with the patient's primary care physician.
- Patients are usually seen at the clinic only once, then followed by an ambulatory care manager unless they are having home health services. Then the care manager picks up after the patient is discharged from home health.
- The Care Coordination Clinic also sees patients who have not been hospitalized, but who have been referred by the emergency department staff or community physicians because their chronic conditions are deteriorating or they need palliative care.

care providers," she says.

Most of the patients the ambulatory case managers work with have had multiple hospitalizations. Sometimes they are people who are not high risk enough to be referred to the clinic but have a limited need, like a transportation issue, Ecklund adds.

The ambulatory case managers coordinate care between multiple practitioners, help patients connect with community programs and services, educate them on their conditions, and help them follow their treatment plan.

Patients who receive case management through the Care Coordination Clinic or from ambulatory case managers have not necessarily been hospitalized. "There may be patients in the community that we identify as having decompensating health. We try to intervene to prevent hospitalizations or to get the right plan of care in place so they don't deteriorate further," Ecklund says.

Some patients are referred to the clinic after an emergency department visit, she says. Others are there for palliative care.

Physicians also can refer their program to the clinic for follow-up if their illness is causing significant suffering or is terminal, Dheeriya says. For instance, a physician may refer a patient who is close to end-stage chronic obstructive pulmonary disease but still wants treatment, or someone receiving chemotherapy who needs pain management.

"We transition them to a supportive care model that meets their needs before hospice is appropriate and helps them avoid hospital admissions," she says.

REFERENCE

1. Project BOOST (Better Outcomes by Optimizing Safe Transitions) is a series of interventions to improve the hospital discharge process. For more information, visit www.hospitalmedicine.org. ■

Electronic system, anonymity improve reporting

System can increase quantity and quality of reporting, experts say

Incident reporting appears to improve when employees are provided an anonymous method, according to the experience of Montefiore Medical Center in Bronx, NY.

The use of the anonymous reporting system grew out of the hospital's adherence to the Agency for Healthcare Research and Quality's Common Formats method of incident reporting. Patient safety organizations — Montefiore is a member of one — are required to collect and analyze data in a standardized manner, and the Common Formats method helps providers uniformly report patient safety events and aims to improve healthcare providers' efforts to eliminate harm.

One of the options included in the Common Formats is anonymous reporting, and Montefiore included that method when it implemented an electronic incident reporting system in 2012. Among other features, the system enables hospital staff to submit anonymous incident reports of patient safety issues for analysis and improvement. The previous process at Montefiore had employees filling out a one-page paper form.

Transitioning to the electronic reporting system greatly increased the quantity and quality of reporting, says **Jason Adelman**, MD, patient safety officer at Montefiore. Adelman did not specify specific numbers but said the increase was more than he expected and made him realize that many safety concerns had gone unreported in previous years.

The quality of the reports improved because the anonymity, and the ease of reporting electronically, prompted people to share their concerns more fully, with details that typically were not provided in earlier reports.

Not all of the reports are anonymous, and Adelman says it is unclear how much of the increase in reporting was due to that feature. However, he says he suspects the anonymous feature has led to the reporting of some incidents that might have gone unknown. "The message we send is that we are interested in finding out what the system problem was that allowed that error or that near miss to occur, not to punish the person who made a human error," Adelman says. "Anonymous reporting is a way to encourage that."

Protocol at Montefiore requires the staff member who becomes aware of a safety issue to complete a written report through the system, from which trending and

investigation reports are produced. Incident reporting is required for unsafe conditions, near misses, and adverse events resulting in actual harm to a patient. Montefiore's data is shared with the ECRI Institute's Web-based Patient Safety Organization (PSO), where it is merged with and compared to the error reports from healthcare institutions nationwide. Data from the ECRI PSO is used by Adelman and colleagues in developing and testing appropriate interventions, such as efforts to reduce wrong-site errors and medication mistakes.

"With every medical error root cause we identify, we are saving lives, and our physicians are a critical link to helping us identify those causes," Adelman says. "There are many vendors and systems you can use for incident reporting, but my main recommendation is to use the Common Formats in whatever system you choose."

More information on AHRQ's Common Formats is available online at http://www.pso.ahrq.gov/common. ■

Hospital meets Triple Aim goal, improves safety

System provides real-time monitoring

In its efforts to achieve the Triple Aim quality goal, Lafayette (LA) General Health has implemented flexible systems, along with standardized equipment and monitoring solutions that improve patient safety and overall quality at the health system.

The Triple Aim is a framework for healthcare improvement based on three primary goals: improving the patient experience, improving the health of populations, and reducing the per capita cost of healthcare. Implementing a new electronic record and electronic monitoring system was a significant step forward for the Lafayette hospital, says **Jamie Gonzales**, RN, BSN, clinical educator at Lafayette General Health.

The new monitoring system was only part of the effort, Gonzales says. One task was to gain a better understanding of the patient experience and to improve that experience. A better interaction among staff also was desired, so Lafayette asked employees to define what they expect from their coworkers. The health system educated frontline staff on the importance of small gestures such as introducing themselves properly to patients and coworkers.

"It was the little tiny things that overall made a huge impact on the perceptions of both patients and employees," Gonzales says. "Our quality measures weren't what we wanted, so we started making rounds daily through every single floor, even on the weekend, to ensure that every single core measure was met and no one was left behind."

Much of the improvement effort focused on empowering nurses. Lafayette also implemented hourly rounding by nurses, which reduced falls and improved outcomes overall, Gonzales says. The clinical education department was completely rebuilt to provide more thorough and ongoing education beyond initial orientation.

The new electronic system provides more real-time monitoring to detect early changes to vital signs, bed exits, pressure ulcers, and respiratory failure. This monitoring has led to 75% reduction in mortality rates and 40% reduction in cost of care. Custom alarms also alert staff before the trouble occurs, such as when a patient is trying to exit the bed. Vital signs errors have been reduced by 75%.

For a typical 200-bed hospital, this change alone can equate to savings of $2 million in operational costs, says **Garrison Gomez**, senior director of vital signs and cardiology for the United States and Canada at Welch Allyn in Skaneateles Falls, NY. ■

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.

COMING IN FUTURE MONTHS

- The case manager's role in improving patient satisfaction
- Why collaborating with post-acute providers is becoming even more important
- Inpatient vs. observation in a changing healthcare world
- How the CMS bundled payment initiative is working

HOSPITAL
CASE MANAGEMENT

CNE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right or log on to AHCMedia.com, then select "MyAHC" to take a post-test.

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form.

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CNE QUESTIONS

1. According to Sue Dill Calloway, RN, MSN, JD, CPHRM, CCM, CCP, case managers promote patient safety through ensuring a safe discharge, improving outcomes, and preventing unnecessary readmissions.

A. True
B. False

2. According to Patrice Sminkey, RN, chief executive officer for the Commission for Case Management Certification, what should case managers do when they see a safety breach?

A. Educate the person making the mistake.
B. Report the breach to their supervisor.
C. Write a note to the hospital's patient safety officer.
D. Do nothing because it's not their job.

3. When the U.S. Congress passed legislation that removed the sustainable growth rate methodology for payment for physician services, it also delayed enforcement of the controversial "two-midnight rule" through what date?

A. April 30, 2015
B. September 30, 2015
C. July 1, 2015
D. January 30, 2015

4. At-risk patients at Torrance Memorial Medical Center are referred to the hospital's Care Coordination Clinic for follow-up care. How soon after discharge is the appointment?

A. Within 24 hours
B. Within 48 hours
C. Within 72 hours
D. Within a week