HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE



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# Don't Leave Managing Patient Throughput Off Your To-do List

*Timely discharges are more important than ever*

In the ever-changing healthcare world with new focus on reimbursement for the entire episode of care, penalties for hospital readmissions, and questions about inpatient versus outpatient status, case managers still need to be concerned about moving patients through the continuum as quickly and safely as possible.

The healthcare system is rapidly changing, but the need to manage length of stay hasn't changed, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts.

"With payment reforms such as bundled payments and Medicare spending-per-beneficiary, hospitals still have to manage length of stay. In a true case management model, one of the roles of case managers is to manage patient flow. Case managers have an

## EXECUTIVE SUMMARY

Maintaining good patient flow is more important than ever as CMS and other payers move toward payment reform basing reimbursement on the entire episode of care.

- Making sure patients move smoothly through the continuum is part of the case manager's responsibilities and is essential to the hospital's bottom line.
- Complete patient assessments and start discharge planning on Day 1, or before the patient arrives if the admission is planned, to eliminate last-minute problems that contribute to avoidable delays.
- Establish what happens during every step of the hospital stay, identify where the bottlenecks occur, and take steps to make improvements.
- Case managers should cover all access points to ensure admitted patients meet inpatient criteria and arrange services at another level of care if they don't.



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obligation to identify delays and work to eliminate them," she says.

Eliminating avoidable days is still a good way for hospitals to recover revenue and to use their resources more efficiently, adds **Bonnie Barndt-Maglio**, PhD, RN, managing director of Chicago-based Prism Healthcare Partners. "New regulations from CMS and other initiatives such as bundled payments and the readmission reduction program are getting a lot of attention, but the foundational work of case managers is to address excess days," she says.

"When hospitals take on more risk, whether it's through bundled payments or other forms of reimbursement, patient flow has a huge impact," says **Connie D'Argenio**, MS, BSN, managing director of Huron Healthcare Practice at Chicago-based Huron Consulting Group. "Good patient flow and optimal use of the inpatient setting are essential components of an effective bundled payments strategy. Managing the placement and transition of patients is part of a case manager's responsibilities and it can affect the hospital's success," she says. *(For tips on improving patient flow, see article on page 164.)*

Hospitals need to have a process in place to ensure on a daily basis that care is being progressed, including whether the patient is receiving the appropriate level of care, D'Argenio says.

Not only do timely discharges benefit the hospital's bottom line, it benefits the patients as well. "Patients can pick up an infection in the hospital, and the sooner patients are back in their own environment, the sooner they recover if they have a good discharge plan and all the services they need are in place," Barndt-Maglio says.

Historically, case managers have been the ones who were responsible for making sure care is progressing, reducing fragmentation, and ensuring everybody on the treatment team is moving in the same direction, adds **Mindy Owen**, RN, CRRN, CCM, principal owner of Phoenix Healthcare Associates in Coral Springs, FL, and senior consultant for the Center for Case Management.

"That hasn't changed, and case management is more necessary today than ever before. People are beginning to appreciate the value that case managers bring to healthcare and the role that nobody else fills. At the same time, the responsibilities are increasing and we've seen an increase in the number of tasks case managers have to juggle," Owen says.

In fact, as changes in the healthcare system have changed the scope of the job for case managers, the term "care manager" is more appropriate, adds **Mark Krivopal**, MD, MBA, vice president at GE Healthcare Camden Group in Boston.

"Case managers traditionally have concentrated on the inpatient stay, but the role is evolving to the role of 'care manager' who looks at what's happening at all points in the episode of care," he says.

Good patient flow in the inpatient setting remains critically important, and reducing avoidable days is gaining in importance as payers move toward global payments, Krivopal adds.

Hospitals often begin initiatives to improve throughput because of long waits for beds in the ED or surgery recovery area, Barndt-Maglio says. "But the emergency department and operating room are not the cause of the problem — they are the victims of bad patient flow. If admitted patients get the services they need

and are discharged in a timely manner, it opens up inpatient beds for more patients," Barndt-Maglio says. *(For information on how having case managers in the ED can improve patient flow, see related article on page 165.)*

Barndt-Maglio estimates that 80% to 90% of avoidable delays occur during patient stays of 0 to 5 days.

One of the most common delays is execution of the discharge plan in a timely manner, she says. Delays may occur as the discharge day approaches. It may be that the patient doesn't have transportation home, or the family hasn't chosen a post-acute facility, or the physician is waiting on a test or an evaluation.

"Case managers can't move patients through the continuum alone. They should develop a strong relationship with their hospitalist team and the rest of the interdisciplinary team and work together on patient flow," Barndt-Maglio says.

Take a proactive approach and assess patients as soon as they come into the hospital and start to work on the discharge plan, Barndt-Maglio suggests.

"If case managers understand the patients' needs on day one, they can arrange for services early in the stay and not wait until the last minute, delaying discharge," she says.

Patient flow initiatives should start even before patients come to the hospital, when admissions are planned, Krivopal says.

Traditionally, when hospitals looked at patient flow, they focused only on the time the patient was in the hospital, Krivopal says. "This is still important, but as we move into more sophisticated alternative payment models, the management of patients and oversight of what happens has to extend outside the hospital," he says.

For instance, when elective surgery is scheduled, care managers should conduct a comprehensive patient assessment that includes screening for comorbidities, living situation, support system, and potential discharge needs so care managers will have the information needed to start the discharge plan. If the patient is likely to need post-acute care, the care manager can start the process of identifying a facility that will meet the patient's needs and is approved by the family, he says.

> "CASE MANAGERS TRADITIONALLY HAVE CONCENTRATED ON THE INPATIENT STAY, BUT THE ROLE IS EVOLVING TO THE ROLE OF 'CARE MANAGER' WHO LOOKS AT WHAT'S HAPPENING AT ALL POINTS IN THE EPISODE OF CARE."

"A lot can happen prior to the patient actually arriving at the hospital that will have an impact on patient flow. Assessing patients in advance is a new concept, but one that can move the patient efficiently through the continuum and reduce potential readmissions," he says.

If patients already know the expected length of stay and their discharge destination before the surgery, they can have their transportation and support lined up. If they choose their post-acute provider, the case managers can line up the services in advance and avoid scrambling at the last minute.

The interdisciplinary team should set the patient's expected discharge date the first time they round on a patient and update it as needed and inform the patient and family, Owen says.

"The discharge date is not set in concrete, but the care manager should lead the team in accomplishing what needs to be done to hit that date whenever possible," Owen says.

"Case managers lead the interdisciplinary team, but they also are the liaison between the finance team and financial counselors from a reimbursement perspective," Owen adds. For instance, the patient may need to complete an application for Medicaid or assistance from community resources. If the patients aren't able to understand the plan of care and have no family support, they may need a court-appointed guardian.

Both examples can take weeks or even months to accomplish, Owen says.

"A lot of factors play into transitions of care, and there may be issues besides the patient's healthcare that have to be managed. It is the responsibility of case managers to keep everything moving," Owen says.

But don't get carried away with moving patients along, Krivopal warns. "The key in both creating and restructuring care under global payment is focusing on the patient from inpatient to home as well as from the ED to inpatient. If patients are at risk for readmission, it may be that an extra day makes sense from both a patient care side and the financial side," he adds. ■

# Five More Strategies to Improve Patient Throughput

Case managers can't create good patient flow alone — it takes a team. The following are some tips from the experts on how you can work with patients and families, physicians, other members of the hospital team, and post-acute providers to move those patients along efficiently and safely.

**• Develop relationships with your counterparts in other settings.** Whether home health agencies or skilled nursing facilities are part of the health system, hospitals need to develop relationships with post-acute providers to provide more cross-continuum care options, says **Connie D'Argenio**, MS, BSN, managing director of Huron Healthcare Practice at Chicago-based Huron Consulting Group. "By developing alignment strategies with post-care providers, case managers can arrange services and transitions to another level of care directly from the ED," she says.

When traditional inpatient case managers have a relationship with their counterparts in other settings, they can share information — resulting in excellent care across the continuum, says **Mark Krivopal**, MD, MBA, vice president at GE Healthcare Camden Group, based in Boston.

"The patients benefit because they get better and more efficient care, the hospital benefits from improved patient flow and a reduction in time spent reinventing the wheel, and physicians benefit because they can focus on clinical care," Krivopal says.

**• Develop creative solutions to the practice of premature admissions.** "I see avoidable days happening across the country when patients come in a day early because of psychosocial issues, and the providers admit them rather than lose the time secured for the intervention if the patient doesn't show," says **Mindy Owen**, RN, CRRN, CCM, principal owner of Phoenix Healthcare Associates in Coral Springs, FL, and senior consultant for the Center for Case Management.

This means that the hospital is essentially providing free care for the day before the scheduled procedure and the patient is taking up a bed that could be available for a patient whose stay will be reversed, she adds.

Some hospitals have a fund to pay for a hotel room for patients who live too far away to make the trip the morning of the procedure and provide taxi vouchers for patients who have transportation issues, she says.

The practice indicates a lack of understanding about admission criteria and medical necessity, and the case manager should provide education for the admitting physician, she adds.

It takes a change in hospital culture so everyone on the staff will understand what a higher level of care is designed for and what doesn't qualify, Owen says. "Until there is a change in the healthcare culture, we are going to see pockets of avoidable days," she says.

**• Develop clear milestones that indicate a patient is ready to move to the next level of care.** D'Argenio suggests the interdisciplinary team determine the milestones based on clinical pathways, or decide on the milestones for each patient during rounds. A milestone might be converting to oral medication from IV medication, ambulating a certain distance, or being able to perform a certain activity without oxygen, she says.

The team should focus on the milestones during interdisciplinary rounds to determine the plan of care for the day, and share the milestones with patients and family members. "When the family understands the milestones the patient needs to achieve to move forward, they can become a partner in the progress," she says.

**• Hold interdisciplinary rounds every day.** If your hospital doesn't have daily interdisciplinary rounds, you're missing an opportunity to work with the treatment team to create a plan for each patient, identify delays in moving the plan forward, and work together to overcome the delays in real time, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts.

Case managers on the unit should be active members of the interdisciplinary care team and interact daily with the treatment team to ensure that the patient progresses toward discharge, D'Argenio adds. "All members of the care team should be knowledgeable about and engaged in the discharge plan, including the patient and family," she says.

D'Argenio recommends that interdisciplinary rounds include that patient's physician, nurse, case manager, and any appropriate ancillary provider such as physical therapists, respiratory therapists, and pharmacists.

During the initial meeting about the patient, the team should go over

the assessment and preliminary care plan, set a potential discharge date, and determine what needs to happen to accomplish a safe discharge. The case manager should write a summary of the meeting, including the goals, and note any delays, Owen says.

The team should reassess the patient and update the plan every day to move the patient toward the discharge, she says.

"Starting from the point of admission, everyone on the treatment team, the patient, and family all need to be on the same page. The team should determine what needs to be achieved each day and what the next milestone will be," D'Argenio says.

**• Determine a discharge target and keep the family updated.** Family decision-making, particularly in end-of-life situations, is also a major cause of avoidable delays, Cesta says. "Some delays occur partly because the case managers don't start talking with the family early on. Often this is because of staffing restraints. Case managers and social workers need to work on flex time so they will be available to family members when needed," she says.

Case managers should keep patients and family members informed about where patients are in the treatment plan and update them regularly on the expected discharge date, says **Bonnie Barndt-Maglio**, PhD, RN, managing director at Chicago-based Prism Healthcare Partners.

Make sure the estimated day and time of discharge is written on the white board in the patient's room on the day of admission and updated throughout the stay so everyone on the team, as well as the patient and family, are aware of it, she adds.

There may be push-back from the interdisciplinary team because of reluctance to estimate a discharge date, she says. "We, as medical professionals, were educated that if you aren't 100% sure, don't write it down. But in the case of the estimated day of discharge, it's a goal and the case manager should make that clear to the patient and family," she says. ■

# It Takes Data to Improve Patient Flow

*Analyze delays and share the results*

Improving patient flow is a two-pronged process: correct delays as they happen, and look at patterns of avoidable delays and develop solutions, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts.

The reasons for delays may vary, Cesta points out. That's why it's important to track delays and look for patterns.

"There's not one right was or wrong way to work on improving patient flow. It depends on the culture of the hospital, the location, the support from hospital leadership, and so many other factors," she adds.

It takes data to identify delays and understand what is causing the delays, says **Connie D'Argenio**, MS, BSN, managing director of Huron Healthcare Practice at Chicago-based Huron Consulting Group.

You can't rely on anecdotal information, she adds.

"What people think caused the delay may not necessarily be a major contributor to the problem. Hospitals need hard data to show what is happening and identify what needs to be changed," she says.

Start by establishing what happens when patients enter the system until they are discharged, and determine what happens to slow the process down, Cesta says. Divide all the delays into categories and examine each category to come up with ways to improve the process.

Concentrate on avoidable delays related to operational inefficiencies, payer issues, delays in transition, or patient placement, D'Argenio suggests.

Look for unwarranted variations in the expected standard of care, D'Argenio says. Keep in mind that patients aren't all alike and some variation is always expected, she adds.

"This isn't standardizing care — it's standardizing the approach and eliminating unwarranted variations in care," she says.

She recommends bringing the entire primary team together to discuss avoidable delays. Make sure the team agrees on the categories to track, and determine who is going to collect information, where it will be collected, and how it will be reported.

Observe what happens as patients move through the system to get an idea of how the patient flow process works in your hospital and conduct detailed time studies at every step, suggests **Mark Krivopal**, MD, MBA, vice president at Boston-based GE Healthcare Camden Group.

Enter delays and causes into a database and aggregate them. Look for volume and patterns to determine where the barriers to discharge are and take steps to correct them, Cesta says.

Analyze patient discharges by the day of the week, suggests **Bonnie Barndt-Maglio**, PhD, RN, managing director at Prism Healthcare Partners in Chicago. "Most of the time, the analysis will show that patients who are discharged on a Monday or Tuesday did not receive services to progress their care on Saturday and Sunday," she says.

Drill down and look for the reasons patients stay over the weekend, Barndt-Maglio suggests. "Sometimes it's organizational issues that arise when services aren't available," she says.

For instance, calculate the number of patients who stay over the weekend waiting for a stress test or other procedure, and conduct a cost-benefit analysis to determine if it would be cost-effective to offer the procedure on weekends, Krivopal suggests.

It could be the physical therapy and occupational therapy departments aren't on hand to sign off on discharges, or there is nobody to read an EKG or echocardiogram, Barndt-Maglio says.

Barndt-Maglio suggests performing a cost-benefit analysis to determine if it would be more cost-effective to have a cardiologist or physical therapist come in for a few hours during the weekend versus keeping the patient for two extra days.

"If there is enough impact on the bottom line, the hospital can take steps to correct the problem and add resources on the weekend — but you have to have data available to justify the additions," Cesta says.

Determine if you could reduce ED boarding time by extending case manager hours in the department. Look at whether hiring more inpatient doctors or non-physician providers would result in orders for tests or discharge issued in a more timely manner, Krivopal suggests.

Create a daily dashboard that tracks key performance indicators and post it in a place where everybody on the floor can see it, Barndt-Maglio suggests. Indicators to track include ED wait time, additional days for patients waiting for nursing home placements, patients waiting for tests and procedures, delays because of transportation, or delays due to family decision-making. Also track excess days associated with patients who stay five days compared to those of patients with longer stays.

In addition, create a physician dashboard that tracks performance on timely discharge.

"We often see physicians whose patients have more excess days, but their readmission rates are the same as or higher than the rates of other physicians," she says.

When a physician has a pattern of excess days, Barndt-Maglio recommends working with the case management physician advisor to talk to the physician.

Another tactic is to assign a case manager specifically to the physician to support moving patients toward discharge. For example, the case manager could suggest that a non-emergent test be performed after discharge. Including the chief medical officer on the team and trending statistics supports the ability to provide guidance to physicians to improve performance, Barndt-Maglio adds. ■

# ED Case Managers Can Prevent Bottlenecks Before They Happen

*Ensuring the right care setting is critical to good patient flow*

Hospitals need to have case management at every point of entry to ensure patients are placed in the most appropriate level of care, says **Mindy Owen**, RN, CRRN, CCM, principal owner of Phoenix Healthcare Associates in Coral Springs, FL, and senior consultant for the Center for Case Management.

"Unless hospitals are looking at patient flow and the payment structure beginning at all patient access points, they are missing an opportunity to truly manage the plan of care," Owen says, adding that the majority of patients are admitted through the ED.

ED case management is essential, Owen says. "Not only do case managers help the medical team determine the appropriate level of care, they determine if the patient is coming to the right facility and the right level of care."

Sometimes the appropriate level of care is not in the hospital setting, Owen points out. It may be that

patients could go home with home health assistance, or have a short stay in a skilled nursing facility, rather than being admitted as an inpatient.

"The emergency department physicians do not have the time or the knowledge of resources to arrange care for patients who don't need hospitalization. If patients don't meet inpatient or observation criteria, the case management team can facilitate a transfer to the right level of care," adds **Mark Krivopal**, MD, MBA, vice president at GE Healthcare Camden Group in Boston.

"Case managers in the emergency department started out being a nice add-on to have, but now they are incredibly important," Owen says. She recommends case managers staff the ED at least 16 hours a day, seven days a week, if not 24/7, depending on the activity and the level of the ED.

Case managers have a major and necessary role in EDs, Krivopal states. "Studies have shown that as hospitals expand the hours that care managers cover the emergency department, the number of unnecessary admissions and unneeded observation services go down," he says.

Many hospitals experience occasional ED bottlenecks that result in patients waiting in the halls until a bed is ready, Krivopal says.

"ED boarding is still an issue. It's always a chicken or the egg: Is the ED so busy and admitting a lot of people, or are the providers upstairs failing to discharge people early?" he says.

Case managers can help by ensuring patients who are admitted save time for their counterparts on the medical-surgical unit by assessing patients in the ED, identifying discharge needs, and even starting on the discharge plan, Krivopal says. ■

# Patient Flow Initiative Eliminates Barriers to Discharge

*Proactive discharge planning was a key*

When patient volume at Intermountain Medical Center reached capacity a few months after the hospital opened, the leadership at the 452-bed teaching hospital knew they had to find new ways to transition patients through the hospital.

As a result of a comprehensive year-long project to improve patient flow, the hospital reduced its severity-adjusted average length of stay by 6.78 hours across all service lines and created approximately 21 "virtual" beds, says **Lisa Graydon**, RN, MBA, chief nursing officer for Intermountain Healthcare's Central Region.

The patient volume at Intermountain Medical Center reached capacity a few months after the 452-bed teaching hospital opened, Graydon says. The medical center, the flagship hospital of the 22-hospital Intermountain Healthcare system, opened in 2007. The hospital leadership expected the 54-bed ED at the Level 1 trauma center to see about 180 patients in 24 hours, but well over 230 patients were being treated.

Working with a consulting firm, the hospital began an initiative to improve patient flow in 2008. It took about a year for multidisciplinary teams to analyze the hospital processes and come up with improvements, Graydon says.

The effort started with analyzing how patients were transitioned from all points of entry, including the ED, the operating room, and the catheterization lab.

Using data from the hospital's electronic medical record and the admit, discharge, and transfer system, the team conducted time studies of the hospital's processes that involved patient throughput. For instance, they measured the time it took from the

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When Intermountain Medical Center in Murray, UT, reached capacity a few months after opening, a year-long initiative on patient flow determined that part of the holdup was taking care of last-minute details.

- Each unit holds a multidisciplinary care coordination meeting every day to discuss each patient and what they need to go to the next level of care.
- The team sets an anticipated discharge date during the first meeting, giving everyone on the team a target for carrying out their responsibilities.
- The unit charge nurse chairs the meetings and ensures team members carry out their responsibilities for moving the patient toward discharge.

time the admission orders were issued until patients were in a bed; how long it took to transfer patients from one unit to another; how long it took for housekeeping to turn over rooms; and how much time elapsed from the time the discharge order was written until patients were out the door. "We looked at hundreds of metrics to determine where the bottlenecks occurred, what caused them, and what we needed to improve," she says.

The analysis showed that one of the barriers occurred when patients were being discharged or transferred to another facility because some of the arrangements didn't happen until the last minute.

"We found that we weren't always putting all the pieces together and designating who was responsible for what. The transition time arrived and there were still last-minute details to manage," Graydon says.

"We knew that planning for the discharge had to begin on day one. If we know where the patients are going from the moment of admission, we can ensure that patients get the right care at the right time in the right place," she adds.

Members of the patient flow team included hospital leadership, physicians, nurses, case managers, therapists, and representatives from environmental services.

The team collaborated with the discharge planners, case managers, and social workers on their process and opportunities for improvement. One of the first changes was to combine utilization review and discharge planning responsibilities under a unit-based case manager, Graydon says.

The hospital instituted care coordination meetings seven days a week on every inpatient nursing unit. During the short meetings, the entire interdisciplinary team discusses each patient, their anticipated discharge date, and barriers to their discharge or transition to another level of care.

The team talks about what needs to happen before discharge and the appropriate discipline takes responsibility for ensuring it takes place. The unit charge nurse facilitates the meeting and makes sure the discharge needs are met.

"In the past, we were not anticipating the needs until the last minute, but a lot of discharge needs can be taken care of early in the stay. We don't have to wait until the last minute to arrange oxygen or to make sure the patient will have a ride home," she says.

> "WE FOUND THAT WE WEREN'T ALWAYS PUTTING ALL THE PIECES TOGETHER AND DESIGNATING WHO WAS RESPONSIBLE FOR WHAT."

The team set a goal of having patients discharged within two hours after the discharge orders are written. At present, 36% of discharge orders are written by 10 a.m. and 50% of those patients are discharged within two hours of the orders being written, Graydon says.

When patients are admitted to the unit, the physician and the rest of the team decide on an anticipated discharge date, which gives them a goal to work toward. The team documents an anticipated discharge date within 24 hours 93% of the time, Graydon says.

At Intermountain Medical Center, case managers are assigned by unit and teams of hospitalists cover the medical floors. The staff on the medical units coordinate with each other on the time of the meetings so hospitalists can attend the meetings when their patients are being discussed.

The care coordination meetings are very specific and focus only on what the team needs to do for patients that day and the next to help them progress toward discharge, Graydon says. For instance, the team might determine the patient needs additional teaching or will need orders for durable medical equipment. "The meetings don't replace full rounds or care planning rounds. Those take place at another time. They are strictly patient flow meetings," she adds.

They keep the patient and family informed about the discharge date so they can arrange for transportation and any other support the patient will need at home, or so they can choose a post-acute provider.

The patient flow team found they had to tackle more than one bottleneck to move patients smoothly through the hospital, Graydon says.

For instance, they knew the day before how many people were having planned surgery and could anticipate how many beds they would need, but they didn't know how many people would be admitted through the ED.

"The care coordination meetings help us plan ahead as much as we can, and the case managers and social workers work on facilitating the discharge plan every day," she says.

When environmental services was paged as soon as a patient left the room, the staff was able to cut 15 minutes off the turnaround time. "Environmental services set a goal of getting a room turned around in 45 minutes or less, which opened up a significant number of beds," she says. ■

# Using Telemedicine to Address Crowding in the ED

Many hospitals already are leveraging telemedicine to quickly connect patients with needed consults for things such as stroke and mental healthcare. However, there is growing interest in applying this same type of technology to the problem of crowding in the ED.

For instance, as part of a larger effort to incorporate digital health solutions throughout its healthcare system, New York-Presbyterian (NYP) is piloting the use of virtual visits for patients who present to the Lisa Perry Emergency Center at NYP's Weill Cornell Medical Center in New York. Administrators say it is a level of service patients have long been requesting.

"When patients go to the ED, one of their complaints and concerns has always been that they wait forever, which for some of the simple things shouldn't take that long," says **Rahul Sharma**, MD, MBA, CPE, FACEP, the emergency physician-in-chief for the Division of Emergency Medicine, an associate professor at Weill Cornell Medicine, and the medical director of strategic initiatives and the "Making Care Better Program" for NYP Weill Cornell Medical Center. "We just wanted to give our patients another option at the way they receive healthcare."

## Ensure Safety, Compliance

Sharma acknowledges the idea of providing virtual visits to patients who go to the trouble to travel to the ED for care did not seem like a winning idea to some of the staff initially. They assumed these patients would demand to see a provider in person. However, Sharma compares this new offering in emergency care to what already has happened in banking.

"Several years ago, banks were going up everywhere in New York City. On every single street corner there was a bank," Sharma notes. "When they built up all these banks, people would ask why would anyone go to an ATM when you have a bank and you can just go to the teller."

> "WHEN PATIENTS GO TO THE ED, ONE OF THEIR COMPLAINTS AND CONCERNS HAS ALWAYS BEEN THAT THEY WAIT FOREVER, WHICH FOR SOME OF THE SIMPLE THINGS SHOULDN'T TAKE THAT LONG."

Now, people rarely go inside a bank just to get cash from the teller, says Sharma, and he thinks patients are yearning for the same kind of convenience when they require medical care, although he stresses that this approach is suitable only for patients with lower acuity conditions — at least at this stage.

People with chest or abdominal pain, or people who require long workups or CT scans are not ideal for the virtual approach, Sharma explains. However, he notes that a significant chunk of patients who present to the ED have colds, small wounds they need to get checked out, or other minor conditions that can be managed safely by a provider who is seeing them via telemedicine hookup, especially when other aspects of care are in place to ensure safety.

"While the patient is being seen virtually, they have already been seen by a physician assistant [PA] or a nurse practitioner [NP] in the triage area," Sharma explains. "They have had vital signs taken, they have already had a formal triage and all the other requirements have been done, so these people aren't just getting whisked into a room and whisked out. We still have to follow our requirements, and we want to make sure we are doing this in a safe way."

## Target Wait Times

While the process is still quite new, initial results are promising.

"We initially offered the service for four hours a day. We then expanded it to six hours, and now we have expanded it to eight hours a day Monday through Friday," Sharma explains. "We plan to expand this to 16 hours a day."

On average, over a period of four to six hours, three or four patients are seen via telemedicine, and that should double when the service expands to 16 hours, Sharma notes.

"These are patients who would otherwise spend a couple of hours in the ED, and they are in and out within half an hour, which is just

unheard of," according to Sharma, and he notes there are benefits for emergency providers as well.

"What it does is allow our [on-site] physicians and providers to focus on other patients," Sharma says. "What we are essentially doing is decanting the ED [of] these simple, lower-acuity patients so [providers] can spend more time with, and get other patients out, sooner."

This is becoming more important, Sharma says, because despite some predictions that passage of the Affordable Care Act would reduce ED volume, the opposite has occurred.

"If you look at the numbers nationally, the number of visits to the ED actually has gone up," he says. "More patients are coming to EDs, making it more challenging for providers, so if we can offer services that take a chunk of these patients away from our [on-site] providers and have someone else take care of them, that results in improved overall operational efficiency for our ED."

## Educate Staff

Interacting with patients is the easy part of offering care via telemedicine in the ED, Sharma notes. Integrating the offering into the workflow of the ED presents more challenges.

"As with any initiative, we had to make sure we had buy-in from our nurses and staff members as well as our physicians because there is no point of doing something unless you have buy-in from your staff," he says.

Also critical is getting everyone educated and comfortable with the new process.

"From the time a patient comes in, if your front-end intake process, your triage process, is not well-designed and it is not robust, then this won't be a success," Sharma explains. "Everyone from patient services to the registrar to the greeter nurse and the [PA] or [NP] who is examining the patient has to be on the same page and well informed."

Sharma notes that in NYP's program, the PAs and NPs in the triage area are equipped with scripting on how to introduce the program, which is voluntary, to appropriate patients.

"They have to explain that we are trying a new program where the patient can be seen by one of our same doctors, but by telehealth monitor in a private room with convenient chairs," he says. "These are board-certified, Weill Cornell faculty attending physicians. They are sitting in a room that is essentially an old office that is equipped with monitors. It is not in the ED."

> "WHAT WE ARE ESSENTIALLY DOING IS DECANTING THE ED [OF] THESE SIMPLE, LOWER-ACUITY PATIENTS SO [PROVIDERS] CAN SPEND MORE TIME WITH, AND GET OTHER PATIENTS OUT, SOONER."

Patients also have the option of visiting the "fast track" area of the ED in which they likely will wait between two to three hours to see a provider, Sharma explains.

"If you tell patients that, they will say, 'Why not try the new program,'" he says. "We were actually a little surprised at how many patients agreed to this program. I do want to emphasize, though, that this is not for all patients. This is for patients with minor issues — not for complicated workups where physicians really need to physically touch the patient."

Sharma adds that a critical element to successfully offering virtual visits in the ED is making sure facilities provide the same high level of care to a patient regardless of whether that patient receives in-person treatment or virtual telehealth services.

"You have to follow all the rules and regulations to make sure that you do this in a safe manner," he says. "That's why we make sure that all these patients have gone through triage, have gotten vital signs taken, and are appropriate candidates. What we don't want to do is open this up for all patients."

Payment for virtual visits is just the same as if the patients were treated in person. There is no additional charge for telehealth, Sharma notes, and thus far, patients seem very pleased with the approach.

"We have had patients from the ages of 21 to 91, and we called back many of them to see how they liked the experience," he says. "I would say most of them loved the experience and wouldn't want it any other way."

Buoyed by these early results, NYP plans to expand the telehealth option to a second hospital soon, and to closely monitor the effect on ED throughput as well as the overall patient experience.

"If this all goes well, we could see this expanding to other NYP sites as well," Sharma adds.

## Address Hurdles Early On

While NYP is one of the first

health systems to pilot virtual visits in the ED, there have been earlier efforts. For instance, back in 2013, the University of California San Diego Health System launched a pilot to determine if telemedicine could help ease crowding by leveraging on-call physicians remotely when the ED gets busy. Hillcrest Medical Center, a Level I trauma facility that was treating about 60,000 patients a year in the ED at the time, implemented the approach.

The pilot consisted of an on-site telemedicine module that included a video screen, a camera that could be controlled by the remote physician, and tools to enable the physician to evaluate a patient during the telemedicine encounter. A dedicated, on-site nurse would handle the peripherals — placing a stethoscope where instructed by the remote physician, for example.

The most critically ill patients were not treated remotely, but there were no set criteria limiting what types of patients could be seen via telemedicine, although the approach was designed primarily for patients who were deemed safe at triage to be sitting in the waiting room while the ED was full. During the pilot, investigators noted that while most of the patients treated via telemedicine were on the lower acuity side, some patients required hospital admission.

Investigators had high hopes for the approach. The thinking was that eventually one off-site physician potentially could examine patients from several different EDs, improving efficiency and throughput at multiple sites in the health system. However, the approach never got beyond the pilot phase. **Benjamin Guss**, RN, the nurse champion of the telemedicine project, dubbed the Emergency Department Telemedicine Initiative to Rapidly Accommodate in Times of Emergency (EDTITRATE), explains that part of the problem was that the model required the involvement of both a remote physician and an on-site physician.[1]

"A telemedicine physician would be seeing the patient primarily, but then at the end of the visit the telemedicine doc would have to discuss the case with an on-site doc, and then that emergency physician would basically give the blessing to whatever the diagnosis was or the discharge or admission [decision], so it [required] taking two physicians to see one patient, which really bogged down the whole system," Guss explains. "It took the [on-site] ED physician away from seeing other patients, and it ended up just taking a lot longer to get through one patient."

The involvement of the on-site physician was necessary because, at the time, some insurance companies required this step for reimbursement, and some clinician leaders at the hospital wanted the on-site physician involved out of liability concerns, Guss explains.

Despite these administrative hurdles, patients were receptive to receiving care via telemedicine.

"It went really well. We saw about 85 patients, and there were no bad outcomes with any of them," Guss recalls. "Some patients would even come back and ask for [a telemedicine visit] again when they presented to the ED. Unfortunately, though, we weren't doing it every day; it was only used when the ED was busy."

The pilot lasted for about six months, never moving beyond the pilot stage, but Guss notes there is still interest in restarting a telemedicine approach in the emergency setting if the insurance and liability concerns can be addressed.

"I really enjoyed doing it and think it can be a big success and work well in the ED," he says. "We are just waiting for a good time to start it up again."

Guss's advice to emergency medicine colleagues interested in developing a telemedicine approach is to have a clear plan in place, get everyone involved to agree to the plan, and make sure that insurance companies are on board with the approach as well.

Sharma from NYP echoes these sentiments, noting that getting the workflows right is the biggest challenge. He also notes that providers and staff have to understand fully how the process will work before launch.

"While it is a new service, some people may not be comfortable doing this, and some patients may not want to do this," he says. ■

## REFERENCE

1. Toila V, Castillo E, Guss D. EDTITRATE (Emergency Department Telemedicine Initiative to Rapidly Accommodate in Times of Emergency). *J Telemed Telecare* 2016; doi: 10.1177/1357633X16648535.

## COMING IN FUTURE MONTHS

- Updates on the CMS audit program
- How your peers are reducing readmissions
- Staying ethical in today's world
- How to improve your hospital's Star Rating

HOSPITAL
CASE MANAGEMENT



# CE INSTRUCTIONS

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# CE QUESTIONS

1. **According to Bonnie Barndt-Maglio, PhD, RN, 80% to 90% of avoidable delays occur during stays of what length?**

   A. Two midnights or less.
   B. 0 to 5 days.
   C. 5 to 7 days.
   D. More than a week.

2. **According to Toni Cesta, RN, PhD, FAAN, partner and consultant in Case Management Concepts, what should the team do during interdisciplinary rounds?**

   A. Create a plan for each patient.
   B. Identify delays in moving the plan forward.
   C. Work together to overcome the delays in real time.
   D. All of the above.

3. **How many hours a day does Mindy Owen, RN, CRRN, CCM, principal owner of Phoenix Healthcare Associates, recommend that case managers staff the ED?**

   A. 24/7
   B. 12 hours weekdays and 8 hours on weekends.
   C. At least 16 hours a day.
   D. Depends on the hospital.

4. **What is Intermountain Medical Center's goal for discharging patients after the discharge order is written?**

   A. Within two hours.
   B. Within four hours.
   C. Depends on the unit.
   D. By 5 p.m. that afternoon.

# CE 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.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

# The Process of Managing Long-Stay and Difficult-to-Discharge Patients

*By Toni Cesta, PhD, RN, FAAN*

## Introduction

Discharge planning has become a much more complex and challenging process — and a process it is! We can no longer think of it as a destination, but rather as a continuation of the care the patient has received. The discharge planning process must consider both the services provided to the patient before admission as well as those they will receive after discharge. It is a process, not a destination. Included among these patients are those most difficult to plan for: those patients who may linger in the hospital without intense and focused case management interventions and discharge planning.

This month, we will discuss ways in which your case management department can facilitate the management of these most complex patients. The interventions needed include both a process as well as a specialty position in the case management department to remove the undue and time-consuming burden of discharge planning of these patients to a dedicated provider. By providing this process, you can better ensure that these patients will receive the right care while in the hospital, and the most appropriate care they may need along the continuum as well.

BY PROVIDING THIS PROCESS, YOU CAN BETTER ENSURE THAT THESE PATIENTS WILL RECEIVE THE RIGHT CARE WHILE IN THE HOSPITAL, AND THE MOST APPROPRIATE CARE THEY MAY NEED ALONG THE CONTINUUM AS WELL.

## Complex Discharge Planning and Long Length of Stay

The notions of complex discharge planning and long length of stay patients have become intertwined in our vernacular in case management. In fact, these may very well be two distinct groups of patients. You may think of them in this way:

- **Complex discharge planning patients:** Patients with complex problems and issues that result in the need for extended and labor-intensive discharge planning.
- **Long length of stay patients:** Patients whose length of stay has exceeded a pre-established length of stay benchmark.

Let's start off by describing each group of patients.

## Complex Discharge Planning Patients

First, the complex discharge planning patients. These are the patients who are difficult and time-consuming to plan for, and create, a discharge plan with a viable destination. The reasons for this can be varied. Examples might include the following:

- undocumented,
- uninsured,
- underinsured,
- John or Jane Doe, and
- highly medically complex.

These patients can absorb large amounts of time from both the RN case manager and the social worker in the process of facilitating a discharge plan. While the RN case manager and the social worker are working on these patients, other more routine patients may be neglected or overlooked. This can result in a trickle-down effect whereby the length of stay can go up for all the patients in that RN case manager or social worker's

caseload. For this subset of patients, it makes good sense to move them to the caseload of a dedicated discharge planning specialist. This allows the more routine patients to continue to move through the acute care continuum in a more timely fashion. We will discuss the role of the discharge planning specialist shortly.

Complex patients who fall into this grouping may or may not have a prolonged length of stay. However, by getting to their plan earlier and by assigning a dedicated social worker or RN to manage their discharge planning needs, you can better ensure their discharge planning needs are met in a more efficient and timely manner.

The other subgroup of patients is the long length of stay patients.

## Long Length of Stay Patients

The notion of having a discharge planning specialist serves to try to avoid having long length of stay patients whenever possible. Getting to these patients early and intensively can result in reduction of the volume of these patients. Even with this role in place, there will still be some patients who exceed your hospital's definition of "long stay." Therefore, in describing and identifying these patients, you must first know what your hospital's definition of long stay actually is. By using this as a frame of reference, you can subset these patients more easily for intensive intervention by the discharge planning specialist.

## How to Identify Long-Stay Patients

Acute care length of stay has to do with the amount of time allotted to the diagnosis, care, treatment, or recovery of a patient. All members of the healthcare team own these patients and have a responsibility in assisting in managing their length of stay. This responsibility does not belong to the case management department alone. Variation in care can contribute to extended lengths of stay as well as other factors such as lack of coordination and facilitation of care, delay in service, or high clinical complexity.

What defines a long-stay patient in your hospital, or any hospital? This definition should typically be based on determining how many excess days define about 20% of the population in your hospital. Excess days refer to the days beyond the patient's expected length of stay as defined by their DRG. This is a calculation that your case management department will only have to figure out once and re-evaluate on an annual basis. If your average excess days per discharge average five days, then any patient with a length of stay of one day, or 20%, beyond the expected length of stay, would qualify for this category. The determination of the expected length of stay would be based on the presumptive diagnosis and the physician's plan of care. Needless to say, when done concurrently, this is not an exact science.

You can also place patients into this grouping when it is clear they are going to become a long-stay patient based on the issues presented. This prospective approach can also contribute to a better management of their length of stay as you "get on the case" earlier. Both approaches should be used and it will get easier to identify these patients over time as you practice at it.

From here, you must then determine the causes of the excess days and create categories for them. If done correctly, you should be able to capture 80% of your long-stay patients with these categories and add others as needed.

## Categories of Long-Stay Patients

The following is a suggested list of categories that are common to long-stay patients. You can add or subtract from this list as you better identify who your long-stay patients are and the causes of their extended stay.

**• Acute: Patient meets acute care criteria, and the prolonged length of stay is medically necessary and appropriate.**

For this category, use your pre-established criteria such as InterQual to determine whether the patient meets acute care criteria. This makes the decision objective and documentable.

**• Post-Acute Provider Availability: Specialty bed not available such as ventilator, dialysis, isolation or combination of these.**

For this category, patients may be clinically ready to go but simply have no bed to go to.

**• Payer Issues: Delay due to payer approval or lack of coverage for the needed service.**

This category includes both delays in processing caused by a third-party payer as well as patients who are underinsured or uninsured and may not have coverage for the post-acute services they clinically need. Third-party payers can delay due to Medicaid application delays, managed care approval delays, or delays in obtaining a bed through a preferred provider. You may want to break this category into two groups if these are common problems in your hospital.

**• Patient/Family: Issues that**

**arise from the patient or family that cause an extension to the length of stay such as providing paperwork for a Medicaid application, a delay in selecting a post-acute provider or service, family unable to decide between level of care services such as home care versus sub-acute, and end-of-life decision-making such as ventilator removal.**

**• Legal Issues: A delay due to legal issues such as guardianship determination, undocumented, or unidentified patients (John/Jane Doe).**

**• Psychiatric Placement: Delays due to unavailable long- or short-term psychiatric beds or services.**

**• Other: Issues that do not fall into any of the predetermined categories.**

Once you have identified the categories you would like to use, you can catalog the patients into one of these groups. Each patient's entry should include the reason for the extended length of stay, the length of stay (this will be a continuously changing number), and the plan to address the causes of the delay.

Placing your data into a graph or chart can also help with tracking. An example might be the use of a pie chart to demonstrate the volume of patients in the various categories. However you choose to identify and catalog your long-stay patients, the following strategies should always be incorporated into the process:

• update your list of patients weekly,

• catalog issues for future reference, and

• report to utilization review committee monthly.

## The Discharge Planning Specialist

Once you have identified your long-stay patients and your process for managing them, you must also think about who in the case management department is best positioned to carry them on a discreet and specialized caseload. This position can be filled by a social worker or a nurse case manager. It must be a dedicated position that is used only for this purpose.

The role should be filled by an experienced social worker or nurse who has extended experience in discharge planning. The person filling the position should also be a creative thinker who is excellent at problem-solving and who has good communication skills. The position also requires someone who is good at managing and reporting data.

THE PURPOSE OF THE ROUNDS IS TO WORK AS A TEAM TO IDENTIFY INTERVENTIONS AND SOLUTIONS TO CORRECT THE ISSUES CAUSING THE INCREASED LENGTH OF STAY.

The caseload for the discharge planning specialist must be fluid as it may be larger at some times and smaller at others. The average should be about 20 patients, but should be ultimately dependent on the complexity of the patients that the specialist is managing at any point in time. Once the specialist has been assigned a patient, he or she should complete a thorough intake or admission assessment. This assessment will provide the foundation for the identification and management of any barriers to discharge for that patient. The RN case manager should maintain responsibility for overall case management of the patient including utilization management, patient flow, and avoidable delay management.

The specialist also is responsible for documenting in the patient's medical record as appropriate. Documentation should include the specialist's assessment, plan of care, and expected outcomes. Ongoing documentation should be added as needed. In addition to the specialist's documentation, the RN case manager may document in the patient's record as well.

## Long-Stay Rounds

The discharge planning specialist should also plan for, and lead, long patient stay rounds. The rounds should take place on a weekly basis with the goal of reviewing all aspects of the case with a pre-identified team. The purpose of the rounds is to work as a team to identify interventions and solutions to correct the issues causing the increased length of stay.

Members of the committee should include the following:

• discharge planning specialist (chair),

• director of case management,

• manager of social work,

• physician advisor,

• finance department representative in charge of Medicaid applications,

• finance department representative in charge of cost outlier determinations,

• legal department as needed,

• ethics department as needed,

• hospitalist or physician of record

as needed, and

• family member as needed.

The discharge planning specialist should come prepared to present each patient on the long-stay list and to discuss the causes of the long stay and any interventions applied or plans to do so. The finance department should present the financial barriers to the patient's discharge as well as the current charges applied to the admission. The team should brainstorm and identify any potential solutions not already applied by the specialist.

Some ad hoc members may be included as needed such as the legal department, ethics department, the patient's hospitalist or physician of record as appropriate, and/or a family member. If a family member is included, the team should be as small as possible so as not to overwhelm or frighten the family member.

The following can be used to create your own job description for the discharge planning specialist:

**JOB SUMMARY:** This position serves as a resource to case managers and/or social workers working with complex to discharge patients. The discharge planning specialist carries a caseload of complex patients identified by day, dollar, or time intensity outlier designation. Analyzes data to understand the causes and corrective actions for this subset of patients.

**RESPONSIBILITIES:**

1. Focuses on the most complex, time-consuming discharge planning issues/patients.

2. Selects patients from those exceeding the hospital's self-selected long stay threshold.

3. Manages these patients in conjunction with the RN case manager.

4. Coordinates the discharge planning process for complex patients, including those with greater psychosocial acuity, or having time-sensitive needs.

5. Serves as a resource to any social worker or RN case manager who has a complex patient requiring intensive discharge planning.

6. Serves as a resource to city, state, national and international discharge planning challenges such as legal, police, and community liaisons.

SOME AD HOC MEMBERS MAY BE INCLUDED AS NEEDED SUCH AS THE LEGAL DEPARTMENT, ETHICS DEPARTMENT, THE PATIENT'S HOSPITALIST OR PHYSICIAN OF RECORD AS APPROPRIATE, AND/OR A FAMILY MEMBER.

7. Collects and analyzes data regarding referrals and complex cases.

## Summary

To summarize our discussion this month on long-stay patient management, below is a series of strategies for incorporation into your case management department's processes.

**Strategy #1: Identify Long Length of Stay Patients and Related Issues.**

• Define and select your long length of stay categories.

• Select your target long length of stay metric/cutoff point.

• Once patients exceed this benchmark, they should be reviewed more intensely.

**Strategy #2: Review Length of Stay Issues During Interdisciplinary Care Rounds.**

• Discuss the expected against actual length of stay.

• Share the prolonged length of stay issues with the team.

• Even though the problem may not be immediately correctable, it still needs to be discussed each day so the team does not lose sight of the issue or the patient.

**Strategy #3: Conduct Weekly Long Length of Stay Rounds.**

• Occur weekly in addition to daily rounds.

• Focus on predefined long length of stay patients.

• Attended by case management, social work, nursing.

• Progress against corrective actions should be discussed.

**Strategy #4: Implement Discharge Planning Specialist Position.**

• Select social worker or RN case manager to fill position.

• Keep caseloads manageable.

• Report data to utilization review committee.

**Strategy #5: Determine Which Patients are Acute.**

• All non-acute patients should be referred to the discharge planning specialist.

• This will help to offset the workload of the RN case managers and social workers.

• For acute patients, the RN case manager should review daily to determine any changes in status that may require a change in level of care.

• The earlier these patients are identified, the earlier the process can be initiated. ■

# *Hospital Case Management*

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