HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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CMS Issues 2020 Final Rules for Inpatient and Long-Term Acute Care

By Jeanie Davis

The Centers for Medicare & Medicaid Services (CMS) is focused on providing patients with better value and results via competition and innovation. Their final rule, issued in August, updated the Medicare payment policies for hospitals under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) for fiscal year (FY) 2020. Highlights include:

• **Rural hospital wage index adjustments.** Rural healthcare was one focus in last year's proposed rules. Based on the feedback, CMS is improving the accuracy of the Medicare payments to the low-wage hospitals, allowing hospitals to increase staff wages. The idea is that this will help ensure that patients, especially those living in rural areas, continue to have access to high-quality, affordable healthcare.

> "THE WAGE INDEX HAS BEEN A PROBLEM FOR A LONG TIME. THIS IS A GOOD THING FOR RURAL HOSPITALS TO ATTRACT PRIMARY CARE STAFF AND PHYSICIANS."

"The wage index has been a problem for a long time," says **Elizabeth Lamkin**, MHA, CEO and partner of PACE Healthcare Consulting. "The fact that there were two sets — rural and urban wages — created disparity. This is a good thing for rural hospitals to attract primary care staff and physicians."

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This final rule, which goes into effect Oct. 1, 2020, "is a major change whose result will have to be proven because wage is only one of many stressors with rural healthcare," Lamkin adds. "I'm optimistic it will improve rural healthcare. It's certainly a move in the right direction."

The new technology policies will help ensure that Medicare beneficiaries continue to access potentially life-saving diagnostics and therapies, which will remove barriers in competition.

"Rural hospitals must be very careful when vetting new technology and identifying what will be most efficacious for their population," Lamkin says. "Also, the technology requires training and upkeep, so it can become a burden even though it looks good at face value."

CMS also is addressing the issue of hospitals using urban to rural hospital reclassifications to inappropriately influence the rural floor wage index value. CMS will remove these reclassifications from the calculation of the rural floor wage index value.

"This is a change for the better, as there are always people who want to game the system to get their hospital classified as rural when they aren't," explains **Patricia Hildebrand**, RN, MSN, executive director of Hildebrand Healthcare Consulting in Sugar Land, TX. "Some growing areas of Texas, for example, may be classified as rural when, in fact, they are up-and-coming with a great deal of housing and commercial development."

• **All-cause readmissions.** As part of the Hospital Readmissions Reduction Program (HRRP), CMS proposes to remove the Claims-Based Hospital-Wide All-Cause Unplanned Readmission measure. This would begin in the July 1, 2023-June 30, 2024, reporting period. It will be replaced with a hybrid measure that includes claims and electronic medical record (EMR) data.

"This is a good thing, as true clinical factors such as vital signs and lab values will give a better picture of a patient's acuity and severity of illness," says Hildebrand. "It goes back to documentation and using the 13 clinical factors meshed with claims data. These clinical factors should be collected automatically from the EMR so it is not based on narrative info. They should be taking vital signs every day to ascertain the level of acuity."

Hildebrand's only concern, she says, "is for hospitals that haven't progressed in adopting EMR or still upload PDFs instead of entering data, as it won't work. Otherwise, it's a really good thing — a much better picture of where the patient is clinically."

• **Interoperability.** The CMS interoperability initiative encourages professionals, hospitals, and critical access hospitals to adopt, implement, upgrade, and demonstrate meaningful use of EMR technology.

The MyHealthEData initiative launched in 2018 to empower patients with control of their healthcare data. CMS continues to promote interoperability, implementing changes to reduce the burden of compliance. This includes finalizing a new opioid-related quality measure.

"Interoperability is a good thing," says Lamkin. "Interoperability is one of the most important ideas out there. With interoperability and use of EMR systems, we will be more efficient in communication."

The EMR system requires gathering and reporting patient

data using standard methods, with specific inclusions and exclusions based on the needs of specific patient populations. "This will create a much purer information stream, one that's more relevant to the patient's status," Lamkin says. "With EMR systems in place, we will be comparing apples to apples, which will ensure the reporting is accurate."

Hildebrand adds, "Sharing this information with the patient and the doctor is creating very informed consumers, as they should be. They want to receive the information electronically, and we should be able to do that. We need systems that talk to each other, that are part of the same high-tech world as our patients."

• **Interoperability and the prescription drug monitoring program.** Interoperability is the focus of proposals regarding the prescription drug monitoring program (PDMP). For the 2020 EMR reporting period, the Query of PDMP measure is optional and available for bonus points.

Last year, this program faced unintended and unforeseen challenges in implementation and provider burden. To minimize burden, CMS added this function to the nursing station. Discharge of a patient with opioids is now a "yes/no" at the station, says Hildebrand. "This is an example of things that get rolled out, then become very difficult to manage operationally," she says.

This change is an example of how effective feedback can be, adds Lamkin. "CMS asks for this feedback in July every year, when they release proposed changes. Mark that on your calendar. Start watching for proposals so you can provide feedback," Hildebrand says. *(More information on the rule is available online at: https://go.cms.gov/2Kom4Sg and: https://go.cms.gov/2LOKTKb.)* ■

CMS 2020 Final Rules: Infection Control in Inpatient and Long-Term Acute Care

Focus on antimicrobial resistance

By Jeanie Davis

Antimicrobial resistance represents a serious risk for Medicare beneficiaries and for the public overall. CMS is finalizing an alternative new technology add-on payment pathway for antimicrobial products designated by the FDA as Qualified Infectious Disease Products (QIDPs).

Under this policy, a QIDP will be considered new and will not need to demonstrate that it meets the substantial clinical improvement criterion; it will only need to meet the cost criterion. CMS also is increasing the new technology add-on payment to 75% for an antimicrobial designated as a QIDP.

Also, CMS is implementing broader changes to the Medicare Severity Diagnosis Related Group (MS-DRG) severity level designation. Under this change, ICD-10-CM diagnosis codes for antimicrobial drug resistance will be designated as a complication or comorbidity. Generally, this results in a higher severity MS-DRG due to the relatively higher resources associated with diagnoses with such designation.

This ruling "places additional emphasis on patients with serious infections like sepsis," explains **Susan Wallace**, MEd, RHIA, CCS, CDIP, CCDS, FAHIMA, vice president of inpatient services for Administrative Consultant Service in Shawnee, OK.

"The changes regarding diagnosis codes indicate that a patient's resistance to certain antibiotics will be considered an important secondary diagnosis," says Wallace. "That allows the hospital to be eligible for additional reimbursement to cover the patient's care. It's also an incentive for hospitals to make sure the physician documents a patient's drug resistance."

Antibiotics for these serious infections are expensive and wound care is high-level, Wallace explains. "This change is important for hospitals that are not getting reimbursed for the care they're giving. It goes back to documentation, coding, and billing, capturing every detail of the care that was given."

It is important for case managers to access and understand these payment details, says **Patricia Hildebrand**, RN, MSN, executive director of Hildebrand Healthcare Consulting in Sugar Land, TX. "When you're following patients through the course of care, you need to communicate with the physician about their clinical documentation as well as the entire team so everything is included in the documentation."

• **New technology add-on payments.** Every year, CMS has increased the amount of new technology add-on payments for new drugs and lab panels to detect bacteria causing infectious diseases. "We've seen the add-on payments increase up to 75% of the cost, which is significant," Wallace says. The new technology for FY20 includes a lab panel to detect specific bacteria, such as new drugs like antibiotics for complicated urinary tract infection or chemotherapy.

This year, eight new drugs and one label panel have been approved. "This really represents a big emphasis on medication as a new technology. The new bacteria panel will reduce unnecessary use of antibiotics and save the time a patient might be taking the wrong antibiotic. This panel is faster and very accurate."

• **Coding secondary diagnoses.** "The big news here is what didn't happen," says Wallace. In this year's proposed rule, CMS promised to make changes in classification of more than 1,500 secondary diagnoses. "This would have had a drastic impact on hospital reporting and reimbursement," she explains. "But they decided not to make any of those changes this year. That's huge. We were very surprised that they rescinded those changes in the final rule."

An important caveat: CMS has not completely shelved the action. "They needed to evaluate the data and decide how to roll out changes," says Wallace. "It's still important to keep an eye on it. I think they decided it was too much to change at one time, so the changes may be incremental."

The impending changes in coding emphasize the need for case managers to work closely with physicians on documentation in the medical record so that it tells whole story of the patient's illness. "Every year, we see CMS is making decisions based on data submitted in previous years. It continues to raise the need for documentation to be as accurate and complete as possible," says Wallace. "This is an ongoing process because every time we get new codes, CMS evaluates them and makes adjustments to diagnostic-related groups based on what they're seeing in actual practice." ■

CMS Update: Outpatient Total Knee, Hip Arthroplasty

By Jeanie Davis

To provide patients with better value and results, CMS has issued a final rule regarding the inpatient-only list of surgical procedures. This list includes procedures that typically are only provided in the inpatient setting and not paid under the Outpatient Prospective Payment System (OPPS).

Criteria for removing procedure from the inpatient-only (IPO) list includes determining that the procedure is performed in numerous hospitals on an outpatient basis, explains **Deborah Hale**, CCS, CCDS, CEO of Administrative Consultant Service in Shawnee, OK.

For example, total knee arthroplasty (TKA) moved from the IPO list starting in 2018. Total hip arthroplasty is expected to be removed from the list in 2020.

"This does not mean that all procedures described by the code or even a majority of procedures must or should be performed in the outpatient setting, according to CMS," Hale explains. "Removal of a procedure from the IPO list only means that the procedure is no longer precluded from being paid under the OPPS if it is performed in the outpatient setting."

The procedure can be provided on an outpatient basis following a thorough preoperative screening, Hale says. "This will apply to some Medicare beneficiaries, but certainly not all total hip patients."

CMS added another stipulation to the final rule: The procedure must be performed early enough in the day for patients to achieve postoperative goals, allowing home discharge at the end of the day.

"This significantly enhances patient well-being, improves efficiency, and results in cost savings to the Medicare program, including shorter hospital stays, according to CMS," Hale explains. Research also has documented fewer medical complications, improved results, and enhanced patient satisfaction, she reports.

"We do not expect a significant volume of THA cases currently being performed in the hospital inpatient setting to shift to the hospital outpatient setting as a result of removing this procedure from the IPO list,"

Hale explains. "Instead, CMS expects that physicians will continue to exercise their complex medical judgment, based on a number of factors, including the patient's comorbidities, the expected length of stay in the hospital (in accordance with the Two-Midnight Rule), the patient's anticipated need for postoperative skilled nursing care, and other factors."

"Frankly, there are not a lot of Medicare patients who can tolerate that due to comorbidities and home situation," Hale adds. "It's important to remember it's a case-by-case decision. They must have a protocol in place that outlines what patient characteristics would be appropriate for outpatient knee or hip replacement. Also, not all orthopedic surgeons are going to be comfortable moving to the outpatient setting."

Only a small minority of hospitals are performing most TKAs on outpatient basis, she says. "There must be good medical rationale in place, and the decision must be made before surgery."

The home environment must be conducive to the patient's needs. If he or she lives alone, what is the plan for caregiving? Can he or she come in for physical therapy? If not, is home therapy available?

"Also, CMS says it's not going to audit for medical necessity of admission during the first year," Hale adds. "But we've seen audits by Comprehensive Error Rate Testers showing that inpatient status was denied."

She advises hospitals to prepare now for the total hip arthroplasty ruling. "I don't think hospitals should sit back and say 'We've got a year to figure this out.' They need to get protocols in place by Jan. 1 to be sure they're doing as good job as possible. It's important to remember that these don't all have to be outpatient, but neither should they all be inpatient."

Partial hip arthroplasty is proposed to remain on IPO for 2020, she adds. "CMS had proposed to take it off, but orthopedic surgeons pushed back, as those patients are not appropriate for a safe outpatient discharge plan."

The benefits of the outpatient procedure "depend on who you ask and who the surgeon is," Hale adds. "Those getting robotic-assisted knee arthroplasty procedures generally have an easier recovery and do not require a hospital stay. The patients with traditional procedures might be quite as happy to go home the same day."

It is a case-by-case decision based on the surgeon, facility, community resources, and the patient's medical history, she says. "Older patients, in some instances, may be more fragile and less able to manage in an outpatient setting, but there could be some 90-year-olds who can. It's really not an age issue, but an issue of medical condition."

CMS is expected to make a decision about total hip arthroplasty in November. As of press time, the issue is in the comment period. "Total hip arthroplasty patients usually have an easier recovery than total knee, so I expect CMS will approve hip for the outpatient list," says Hale. The change would take effect on Jan. 1, 2020.

Case managers should expect little change on the hospital floor, as most surgeons will continue with inpatient surgery for these procedures, says **Patricia Hildebrand**, RN, MSN, executive director of Hildebrand Healthcare Consulting in Sugar Land, TX.

"Surgeons will want the safety net," says Hildebrand. "If the procedure is outpatient, the surgeon has the option to keep the patient overnight for observation. However, utilization review will require evidence of medical necessity for that."

This new rule will push ambulatory surgery centers to keep patients overnight. "This will lead to mini-centers that perform this procedure on an outpatient basis," says **Elizabeth Lamkin**, MHA, CEO and partner of PACE Healthcare Consulting. "But if the patient hasn't met all discharge criteria, the surgeon may want to keep the patient a few more, or keep them overnight."

She believes patients would prefer outpatient surgery as an "easy in/easy out center if quality is there. But we still must mandate a safe environment for that patient." ■

Centralized Utilization Review: Key Considerations for Successful Implementation

By Jeanie Davis

As hospitals grapple with ever-changing utilization review (UR) guidelines from CMS and consolidate with other facilities, many are centralizing their UR operations.

Under a centralized model, an offsite UR nurse or case manager is alerted when a new patient is admitted and sees all the documentation necessary to determine whether the medical record supports the patient's status. The offsite reviewer then works with the patient's physician or an onsite case manager to receive payer authorization. Offsite reviewers do not see the patient; instead, they complete their review with the electronic medical record and conversations via email or phone with the onsite clinical team.

Centralized UR establishes a standardized common process across facilities, which is a key benefit for multihospital health systems, explains **Brian Pisarsky**, RN, MHA, ACM, a senior vice president for Kaufman Hall's Performance Improvement consulting group.

"In a large system, individual hospitals will often have their own UR processes. Some might be very good, but some might be poor," he explains. "A centralized UR process allows a health system to bring leading practices together. The health system can also establish specialists among the UR staff, with dedicated experts for specific payers who understand their payer's contracts and processes. This helps ensure more claims approvals and less denials."

Centralized UR does not reduce the need for clinical case management, but it can free the case manager (who may have a default UR function) to focus on coordinating care, discharge planning, and preventing readmissions, Pisarsky adds. "Utilization review needs to be timely and done every day. It can fall to lower priority if the case manager has too many responsibilities."

CENTRALIZED UR ESTABLISHES A STANDARDIZED COMMON PROCESS ACROSS FACILITIES, WHICH IS A KEY BENEFIT FOR MULTIHOSPITAL HEALTH SYSTEMS.

Pisarsky's consulting team has seen more hospitals revamping their processes in a move toward centralization. He also has seen a greater focus on contracts to circumvent denials. "We're seeing hospital organizations working with their revenue cycle teams to understand their managed care contracts and UR processes, looking specifically at claims approvals, denials, and appeals," says Pisarsky. "It can make a major difference in improving their denial rates."

Because centralized UR involves offsite reviewers interacting with onsite clinical teams, lines of communication and accountability must be thought through carefully. Pisarsky offers these tips for successful implementation of a centralized UR function:

- **Focus on due diligence.** Work to improve your claims process at every step, he advises. Examine past denials to better understand why they occurred. "Historical data from each payer can be leveraged to improve systems hospitalwide. This can be especially beneficial for smaller hospitals when they join a larger system," says Pisarsky.

Focus specifically on the big-dollar claims first to understand what went wrong, then move to tighten denials on smaller claims. Analyze the details of the contract to see where discrepancies exist and educate UR and case management staff on contract specifics. Where can the UR process be improved? How can patient care teams improve their performance? These are important factors that must be addressed to prevent future denials.

- **Respect the contract's timeline.** Does the contract request a specific time frame for notifications, authorizations, and appeals? If a patient is admitted on a Friday at 4 p.m. and that time frame will fall on a weekend, is UR staff available to cover it? "Many hospitals don't have a weekend protocol in place," says Pisarsky. "We're seeing some managed care companies that require this information over the weekend and will not wait until Monday morning. Hospitals may need a process in place for weekend coverage."

• **Establish one centralized contact point for payers.** Denials carry a deadline for appeals, but too often, a letter of denial will get lost in the health system, says Pisarsky. This is especially true in large multihospital systems where there often is confusion about where denial letters "land." Whose desk or office receives them? Who is accountable for moving this information forward? To whom should the information be sent, and within what time frame?

Each hospital in the system may have its own UR office and business office, and the health system's corporate office also may receive these letters. This confusion can slow the appeals process and could result in missing an appeal deadline. If a centralized UR office is established as the contact point for all payers, this will help limit the number of claims denials that get lost in the health system.

• **Identify a liaison with physicians.** When an admission is concurrently denied, who talks to the attending physician for additional information or to set up a peer-to-peer review? Does a staff member at the centralized UR location call the physician, or does the onsite case manager have the discussion? "Those details need to be worked out," says Pisarsky. "I find the hospital case manager, who collaborates with the doctor on a daily basis, often has the best results. If it's a call from an offsite UR team, someone the doctor might talk with once or twice a month, it's just not as effective."

This decision might also be dictated by the contract. Some payers require the attending physician to complete the peer-to-peer review or appeal. Knowing the details of contracts is vital.

• **Identify a team leader for implementation.** Centralization can pay off in terms of claims and authorization approvals. But it takes a team to develop the new processes, says Pisarsky. "Case management departments need a team leader who takes on the entire project, which can be disruptive for an organization. They need someone who understands the big picture and all the details that must be worked through and who understands the importance of centralized reporting and the power of data."

Communication is the key to these system changes, Pisarsky adds. From admission to discharge, the process of notifications to payers and day-to-day reviews are facilitated via communication. "A centralized process gives each hospital department and each payer a specific person to call, rather than working with multiple individuals at different hospitals," he says.

Although centralized UR can offer many benefits, the decision to centralize is individual to each hospital or health system and should be objectively evaluated in light of an organization's willingness to change and to establish the processes necessary to effectively manage a centralized UR function. Once a decision to centralize is made, the goals and expectations for all involved should be communicated clearly and reviewed often to ensure that implementation stays on track and the goals of centralization are achieved. ■

Case Management Dashboard Can Improve Patient Outcomes

Dashboard highlights daily activities

By Melinda Young

Hospitals and other healthcare organizations can improve patient navigation, quality, and efficiency by creating goals and a plan through data collection and a dashboard.

Health systems are successfully using analytics to engage with electronic medical records (EMRs) and in creating roadmaps for patients, says **Julie Mirkin**, DNP, MA, RN, chief nursing officer of Stony Brook Medicine in Stony Brook, NY. Mirkin has spoken about electronic data collection at national conferences and has worked with a data collection dashboard at a large health system.

"You want patients to navigate through the system effectively," she says. "There's a risk for hospital-acquired conditions. The sooner and faster we can get patients to migrate through the system, the better outcomes there are for patients."

Electronic data collection helps health systems predict roadblocks more accurately. It also helps facilitate faster transitions, Mirkin says. "If someone is waiting for a physician consult, the system can send an

electronic message to the physician, saying, 'We're waiting; the patient needs your services. Would you please come?'" she says. "Every step is tracked by time, so you could measure the response time and hold people accountable."

The reminders are automatic, but case managers still are involved. "We still need the human element," Mirkin says. "People have to document activities in the electronic medical record right after doing a consult."

Mirkin offers these suggestions for best practices in making the most of electronic data collection and interdisciplinary dashboards:

• **Create a plan.** "We can create a roadmap for patients, saying, 'On day 1, they need these things done, and on day 2, these things,'" she says.

The plan should include expected patient accomplishments for each day they are in the hospital. It is important to share daily activities and healthcare interventions with patients so they are aware of what will happen daily. No activity should be a surprise, she adds. If a patient needs physical therapy or a consult before a transition of care, these can be entered in the daily plan.

• **Use a dashboard.** "An interdisciplinary electronic dashboard can highlight patients' daily milestones," Mirkin says.

It can be color-coded and operate like a hospital version of an air traffic control board, she suggests. "If you have a nurse manager with 30 patients, each patient will need something done somewhere," she explains. "The dashboard could turn green when patients get to where they need to be. This information is electronically transferred from the EMR."

• **Take charge.** Case managers can run the meetings and manage the dashboard. Meeting goals might include analyzing avoidable delays and opportunities to be more efficient, Mirkin says.

"You can see delays in real time, like a patient was supposed to have the MRI yesterday, but didn't have it until today," she explains. "You can't manage what you don't measure, and you don't know what your problems are until you really look at the data."

> "YOU CAN'T MANAGE WHAT YOU DON'T MEASURE, AND YOU DON'T KNOW WHAT YOUR PROBLEMS ARE UNTIL YOU REALLY LOOK AT THE DATA."

For example, an analysis of electronic data might show that patient delays happen because specific tests are unavailable on weekends. This could lead to patients staying in the hospital for several days longer than needed. Providing that test on the weekend could save hundreds of days of delays and provide a quick return on investment, Mirkin says. "Plus, it's the right thing to do for the patient," she adds.

The switch from inpatient MRIs to more outpatient MRIs also can be accomplished by a health system adding additional capacity for outpatient MRIs. "Data can drive a lot of efficiency changes," Mirkin says.

• **Monitor orders.** The dashboard also can be used to monitor tests and procedures, ensuring that testing is appropriate at the right time and in the right location.

Often, providers will order patients to undergo certain tests while they are already in the hospital because it is more convenient. But payers might deny these claims, saying the tests should have been performed in an outpatient setting, Mirkin says.

The dashboard can be used to indicate which tests should be inpatient or outpatient. If an MRI or another test is outpatient, then the patient should be discharged and asked to return for the test, she adds.

"A physician, who looks at data from patients whose MRI orders were changed from inpatient to outpatient, might see that this change has had a significant impact on patient outcomes and length of stay," she explains. "It's the right thing to do for the patient, and hospitals will see a financial gain — an increase in radiology revenues because you're doing things in the more appropriate setting," Mirkin says. "It was safer for patients to be at home because it's not in anyone's interest to keep patients in the hospital unnecessarily."

• **Enhance engagement.** The dashboard can improve the hospital's culture of collaboration. "The whole healthcare team becomes very engaged," Mirkin says. "You can put the interdisciplinary dashboard in the lounge for the team to view."

It is more engaging than a verbal report from providers, and it can transform the relationships between healthcare team members, she adds. "Everyone has a single goal, single focus, and everyone is held responsible for their work," Mirkin says.

Creating an electronic dashboard aligns the healthcare team to achieve excellent patient outcomes. "It improves accountability of every team member, which, in turn, increases efficiency, leading to better patient outcomes," Mirkin says. ■

ED Case Managers Can Help Improve Transitions and Outcomes

By Melinda Young

Case managers in the ED can perform more than utilization reviews. In a newer model for their role, case managers can help put ED patients in touch with resources, helping them avoid readmissions and improve outcomes.

For instance, Cleveland Clinic realized that with the changing landscape of healthcare, there is a way care management can put patients in touch with the community services they need to stay out of the hospital and ED, says **Nicole Berman**, MSN, RN, CCM, nurse case manager and nursing manager for the care management department of Cleveland Clinic Akron General Hospital.

"We have care managers in the ER, along with social workers," Berman says. "We try to get those initial assessments done, especially on those patients who end up being admitted." The goal is to start a transition plan as soon as possible, she adds.

Case managers help patients with whatever they will need when they are well enough to leave. "It used to be called discharge planning, but that's frowned upon in our culture because that means the patient leaves here, and then we're done," Berman says. "We're looking at transitioning the person to the next level of care and seeing what we can set up for this patient now that we can hand off the patient to the ambulatory setting."

Placing case managers in the ED setting for transition planning requires a change in culture to look at transitions instead of discharges, she notes. Using the Situation, Background, Assessment, Recommendation (SBAR) handoff method, ED case managers review patients' needs, including home care referrals, Meals on Wheels, or other healthcare and community services, she says.

This does not mean that ED case managers always can finish what they start. It is difficult to complete transitions when patients are there only for a few hours. But they can start the transition process and reach out to a home care nurse and explain what is being set up and what the patient needs, Berman explains. "It takes some trial and error — some experience," she says.

ED case managers can invite hospice, service providers, and community-based organizations to staff meetings, where these leaders can describe their services and what is available for potential ED patients.

"If patients meet the criteria and have need for short-term skilled nursing facility [SNF] placement, then some patients might go straight from the ED to a skilled nursing facility," Berman says. It is challenging for case managers to keep up with SNF bed availability and insurance coverage information, so it is important for ED case managers to stay in contact with skilled nursing providers, she notes.

ED case managers also can stay in close contact with case managers from physician practices and other community settings. "If some patients are seen by specific primary groups, we reach back out to them and they tell us what they've been working on with patients, and then we can hand off patients back to them," Berman says. "It provides nice, continuous care for the patient."

These types of handoffs also work with home care nurses, she adds. "That handoff to the home care nurse is very valuable to us, and we can take it from there and see what we can put together for the patient before they come back home," Berman says. "We're very receptive to it."

Healthcare may be in the age of communication technology, but some of the old methods still work well. "It's interesting to me, in a time and age of such huge technology, that it's still talking to someone, picking up a phone, and finding out what's going on that is easier than trying to find out through a computer," she says. "We still need a lot of people skills."

The ED case management program has resulted in smoother handoffs and care continuum, Berman says. In a population of Akron-based patients, Berman reports 72% of cases that went through SBAR wound up following through on the next step in assigned care. "Everything went smoothly for them, and they did well," Berman says. Of the rest, 17% were not in network, so there was no way of knowing whether they had follow-up care. Eleven percent did not go to their primary care provider for follow-up, but also had not returned to the ED or hospital for observation status, she adds.

"I think it decreases the barriers if patients remain in one healthcare system because everything is accessible through one electronic medical record," Berman says. "We have several large hospital systems that don't use the same EMR, but, geographically, they are close. We don't see all of the history or tests and procedures they've done, and neither

does the other system see ours. It becomes hard to deliver high-quality, continuous care when you're missing part of the information," she explains.

These ED case manager-led handoffs, with or without the help of shared electronic records, can be important in providing continuous care and improving patients' care quality and outcomes. For example, case managers helped a veteran patient get the medication he needed to fight an infection. Veterans sometimes go back and forth between community hospitals and VA hospitals, Berman notes.

"It's not always a smooth transition for those patients," she says. "We had one patient who was discharged with antibiotics for an infection." The patient took his prescription to a VA clinic, but he was told they could not fill the prescription because they did not have his diagnosis at hand. "He probably took just his prescription with him, and they needed a diagnosis for why he was getting an antibiotic — a record of some infection and that this was diagnosed," Berman says.

Until ED case managers began performing handoffs with other providers, they were unaware of the VA's rules on filling prescriptions. "We had done the handoff to the VA social worker for the patient, and we let the social worker know why he was seen," Berman explains.

The social worker happened to be in the clinic when the patient was turned down for his antibiotic and made a quick call to the case manager to ask for the discharge paperwork that was needed to fill the prescription. "We faxed the discharge paperwork to her, and the social worker got the information while the patient still was there, and it all worked out very well," Berman says.

Without the handoff and follow-up communication, the patient would have gone home without his medication, maybe waiting days or a week before trying to fill the prescription again. By then, his infection would have worsened, Berman says.

Employing ED case managers and social workers helps the organization work toward its quality improvement goals, she notes.

"We have a culture of continuous improvement, and all of us are trying to look for ways to do things better and to identify gaps for patient safety and care," Berman says. ■

How to Find the Ideal Case Management Staffing Level

By Melinda Young

No matter what size a hospital and case management department are, there are difficulties in finding the right level of staffing.

"Leaders all over are challenged with this," says **Mickey O'Neill**, MA, RN-C, CMAC, CCM, director of care management at Women and Infants Hospital in Providence, RI.

There is no one-size-fits-all approach because each hospital has its own expectations and sensitive situations in which case management might be needed.

"There might be providers who require things that are not standard for a case management department everywhere, but some hospitals will lean in that direction," O'Neill notes. "They also have to evaluate the overlap between case management and other departments."

The goal should be to have case managers work to the full capacity of their skills and abilities, she adds. "Think about what exactly case managers are doing that really requires someone with that license," O'Neill says. "One example is follow-up appointments. Although a lot of case managers schedule follow-up appointments, is that required for a nursing license?"

There are some methods that case management directors can use to ensure the most efficient staffing levels and expertise. O'Neill suggests the following:

• **Visit units.** "Shadow case managers, go to their units, and ask about their workflow and how they organize their day," she says. "It's important to have informal time to find out what their pain points are and how they experience their challenges."

For example, it might be inefficient to use case managers for precertification of medications when the insurance company often wants to talk to the doctor and not the case manager, O'Neill says.

"We did a project, working with our hospitalist team, to streamline that process," she explains. "Nurses were spending so much time trying to talk to insurance companies to justify medications when they weren't the prescriber."

The solution was to develop

standardized forms and processes, including outlining when it would be necessary to ask a physician for input. "Part of it was getting contact information for providers to call and setting an expectation that they needed to be the ones to get on the phone, and we'd help them with the phone calls," O'Neill says. "It worked."

Another benefit to spending time with staff is it helps a manager find out which employees have computer access to certain information, she says. One unit's case manager might have figured out to create an easy and smooth workflow. Another case manager on another unit might be struggling with this because of technology knowledge or access barriers, she adds.

By visiting case managers in the units, a manager can distribute best practices between case managers on different units. "There's always a challenge to make sure all staff has consistent computer access, but it's talking about work processes with the individuals and helping to facilitate the IT access they need," O'Neill says.

• **Perform a time study.** "Another way of assessing on units is to have staff do a time study," she says.

Employees might not like this because it is time consuming and requires them to write down what tasks they are performing every 15 minutes. "Then, you code it and see where employees are spending their time, including computer time, face-to-face time with patients and families, or making phone calls when something is not right," O'Neill says.

• **Build teams.** "It's really important to take the time to spend with the team and for the team to spend time together, sometimes just doing things that are fun," O'Neill says. "It makes it a lot easier if people need to float to different units or cross-train. When you're looking at all hands on deck, I think team-building helps with staffing."

• **Adjust staff numbers.** "It takes thoughtfulness to adjust the numbers of staff," O'Neill says. "You have to know what your needs are."

For instance, some specialty units might require a different case manager ratio. "Disease-specific units and intensive care units have the capacity to take less time from case management," she says.

"Once you know how many hours per week it takes to just cover your basics, then you also need to have a plan for what the contingency is and how to meet that level of necessary staffing and move people around," she adds. "On the flip side, you have to think about the difference between how many hours people work vs. how many hours they are paid. You have to plan for meetings, vacations, education, and different projects they might be involved in."

Start at their total hours of paid work time for the week and work backward, subtracting for all those activities that take them away from their basic workday activities, she advises. ■

CE QUESTIONS

1. **Which does Elizabeth Lamkin, MHA, say is a benefit to rural hospitals under the 2020 Inpatient Prospective Payment System final rules?**

   a. Generally, rural hospital technology is outdated.
   b. Increasing the wage index can allow rural hospitals to increase staff wages.
   c. Rural hospitals may be able to attract better quality physicians.
   d. Rural hospitals can expand their facilities.

2. **Which does Brian Pisarsky, RN, MHA, ACM, recommend as part of a centralized utilization review (UR) model?**

   a. Analyze the details of contracts to prevent denials.
   b. Add more UR functions to the case manager's duties.
   c. Assign a case manager to liaise with payers, rather than the attending physician.
   d. Using centralized UR to reduce need for clinical case management.

3. **What does the SBAR technique for communication stand for?**

   a. Say, Banter, Answer, Respond
   b. Situation, Begin, Argue, Risk
   c. Say, Begin, Assure, Recommend
   d. Situation, Background, Assessment, Recommendation

4. **Which would be a good reason for asking case management staff to perform a time study that tracks their daily activities and work in 15-minute increments?**

   a. Employees like documenting their workload.
   b. It is a good way to find out which employees are lazy.
   c. It assesses unit's workflow to identify inefficiencies and see how employees are spending their time.
   d. It can be a confidential way of learning employees' competencies and job experiences.

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