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HOSPITAL CASE MANAGEMENT™

the monthly update on hospital-based care planning and critical paths

IN THIS ISSUE

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Can ED case management provide cost-effective care at your hospital?

ED case managers help avoid denials on admission, aid discharge

As case management has matured, so has the scope of case management opportunities. While few hospitals have yet extended their case management system into the emergency department (ED), some hospitals now have a case manager assigned exclusively to that department.

A case in point is Saint Vincents Hospital and Medical Center in New York City. **Suzanne Greenblatt**, RN, MA, the hospital's ED case manager, says her focus varies from day to day and sometimes from hour to hour, depending upon what she thinks is most important. However, her primary focus is reimbursement, and that means reviewing the initial admission diagnosis prepared by the physician.

Her other immediate concern is the appropriateness of the setting, Greenblatt says. In other words, not every patient must be treated in the ED, and not all patients must be admitted to the hospital.

Greenblatt actually begins discharge planning for the patient in the ED, even though it is not presented as discharge planning, she explains. Not only is that an effective opportunity to meet the family and gather information about the patient, including the patient's history, but the family and the patient typically appreciate this.

Her position does not include any social work functions. However, she works in conjunction with two social workers who also are dedicated to the ED, Greenblatt says. "That is very helpful," she says. "If somebody comes into the emergency department and they are homeless or they don't have the resources to buy their medication, I can actually refer the patient to a social worker and concentrate more on true case management issues."

Another hospital that has introduced case management into the ED is Children's Hospital in Pittsburgh. The model employed there varies

because of the pediatric patient population.

Jan Zimmer, RN, CPHQ, director of care coordination at Children's, says one of the hospital's strategies is to collaborate with the staff in the ED to identify patients and families who are considered "at risk" and then network with the children's hospital services internally.

That includes pharmacy, the primary care center, and outside agencies that help facilitate a safe discharge, she says.

Like Greenblatt, she says another immediate consideration is social service involvement. In the ED, history is gathered and Children and Youth Services (CYS) is engaged for possible in-home intervention, Zimmer says.

"Then we provide them information about how to obtain coverage and provide access to prescription and medical equipment and facilitate appointments with the primary care center," she reports.

According to Zimmer, the patient's family is taken to a quiet area where discharge instructions are provided, sometimes using pictures. Then the hospital financial advisor is contacted to help facilitate state assistance.

From a psychosocial standpoint, certain protocols are followed. For example, social workers must be involved with every child younger than 2 years who has suffered a trauma, says **Brett Furlong**, a former social worker at the hospital. There also is a child advocacy group made up of trained clinical social workers who assess possible child abuse or sexual abuse.

Using a child advocacy group has taken a burden off the attending physicians. "We are able to follow through with child abuse issues because we have that core group of physicians," Furlong says. "If there is a case to build, they build it."

The hospital also has developed a resource manual for the staff in the ED. "This has been very helpful," Zimmer says. The manual includes operational instructions such as how to arrange for an ambulance transfer. It also explains how to handle patients with Blue Cross insurance and Medicaid HMOs, as well as the steps that are required.

Any staff can follow those steps and arrange for a transfer that insures payment, Zimmer says. The manual also includes specific discharge instruction tools such as if the child is leaving with a nebulizer or other piece of home care equipment, she adds.

Both hospitals agree that coordinating with home care as early as possible can prove very helpful. "Visiting nurses provide eyes in the home for us," Furlong says. "A visiting nurse will report back to us what exactly is going on in the home and what the household conditions are like."

Social workers then can arrange for proper social service follow-up for CYS, which can help establish an effective and safe home care plan, he explains. Many home care agencies will work with the hospital as long as the patient has applied for Medicaid or other assistance, Furlong adds.

Greenblatt agrees that getting home care started within 12 hours of the patient coming to the ED has proven very effective. As the home health market has become more competitive, she says it has become easier to set up those services.

Documenting benefits

According to Greenblatt, many people outside her hospital have asked about the cost-effectiveness of her position. However, some of the information is still anecdotal, she says.

One focus of attention has been to start patients on antibiotics, where appropriate, as soon as the admission diagnosis is made. "That was not always happening," she reports. "Now, I would say that does happen 98% of the time."

What Saint Vincents refers to as the "denial on admission" rate also has gone down significantly, Greenblatt says. That rate refers to cases where a patient's insurance company decides it is not paying for the admission to the hospital.

Zimmer says her program has yet to employ a database to track activity in the ED, either. "We have a couple of databases we use in the department and have used that on the inpatient side to

collect data," she adds. "But we have not done that much on the outpatient side or in the emergency department."

"We are almost finished with our honeymoon period," she adds. While people were initially very excited about having a care coordinator in the ED, she says the expectation was that this would fix all reimbursement issues. However, apart from anecdotal information, only patients who receive home care are actually tracked.

According to Zimmer, one recent initiative in the area of reimbursement is that before any patient is admitted, the admissions registration staff contact Zimmer and review the case so that she can determine if they are putting the patient into inpatient status.

"That is where we are having issues now," she says.

A certain population of patients who routinely visit the ED requires special attention, Greenblatt points out. These typically are called "social admissions," she says, and Saint Vincents has managed to reduce them significantly.

Greenblatt says she works in conjunction with social workers to provide appropriate services because often times, these patients do not require inpatient or ED services.

Often, these patients are elderly and do not have family, she reports. "They may not qualify for a lot of help at home, but with a little bit of help, they might take their medications regularly and not come to the ED routinely with shortness of breath," she explains.

Several years ago, there were so many social admissions at Saint Vincents that patients actually were rotated through all the services, Greenblatt says.

Today, that is the exception, she says.

According to Greenblatt, that is the result of having staff dedicated to setting up services when patients come to the ED rather than automatically admitting them. In some cases, she says, the night staff will keep patients overnight if they think they require assistance at home instead out of safety concerns.

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Legal liability issues threaten case managers

Discharge planning common source of disputes

Whether case managers realize it or not, they can be caught up in legal disputes regarding their treatment decisions and recommendations. But along with that threat are several steps that can be taken to mitigate their liability.

According to **Kathleen Lambert**, JD, RN, a veteran nurse and practicing attorney in Tucson, AZ, the most common sources for litigation and legal problems for case managers stem from discharge planning.

"One trouble spot is premature discharge including improper transfer," she says. "Another is denial of service."

Failure to communicate or document is a major problem in health care generally, but especially in case management, because of the many people with whom case managers must communicate. "Simply verbally communicating is not always sufficient," Lambert asserts. "You need to document what was done."

According to Lambert, legal problems can arise for case managers in a variety of fashions. Patients may file complaints with hospitals or payers regarding the treatment they received. Those complaints may go to quality assurance or patient representatives or to risk management if it involves an incident. Reports also can be filed with state boards, boards of medical examiners, boards of nursing, or pharmacy boards. In addition, complaints can be registered with Medicare.

Beyond a verbal or written complaint lies the threat of a lawsuit. However, many of these lawsuits are resolved on a local basis or through an in-house resolution and are not published, Lambert notes. As a result, she often gleans information from complaints that are brought before boards, she says. Some of those become public information, and some are used as examples in risk management or quality assurance cases.

National standards of care

One legal issue that all case managers must be wary of is compliance with national standards of care. "There are some difficult issues involved there, because there are potential conflicts between

case managers and their employers," says **Elizabeth Hogue**, JD, a veteran heath care attorney in Burtonsville, MD.

For example, the national standards of care for case managers say that case managers are required to advocate on behalf of their clients, Lambert says. However, some payer employers don't expect case managers to advocate for their patients.

The appeals process for denials often puts case managers in a double bind, she explains. While they are advocating for the patient, many times they also may be representing the company that is either accepting or not accepting the patient.

According to Hogue, another contentious issue is liability for adverse payment decisions. "That remains very much an open issue," she says. Case managers sometimes contend they have no liability because physicians are making the treatment decisions, she adds. "I think they are really sticking their head in the sand when they say that," she warns. "I don't think that works from a legal point of view."

Stick with standards of care

Access to information also is becoming a very important legal issue. That is especially true for case managers who work in the worker's comp area because they often have trouble getting access to the information they need, Hogue says. However, the requirements imposed by the Health Insurance Portability and Accountability Act likely will make this an issue all case managers must contend with.

Here are several steps case managers can take to protect themselves and their hospitals:

• **Stay within the standards of care.**

According to Hogue, the best protection case managers have against liability is to know and understand the national standards of care published by the Case Management Society of America, based in Little Rock, AR.

Lambert agrees that the key is to stay within the standards of care and carefully document why services were provided or denied.

She argues that one of the most important things case managers can do is be aware of their role and the standard of care for that role. That includes an understanding of their job description, because any complaint likely will question whether they operated within the boundaries of that job description and their role as case manager.

According to Lambert, case managers also should maintain an understanding of the alternatives that can be offered and make sure patients are aware of those alternatives as well as the appeals process. She says case managers should learn to present the patient options without letting the conversation become personal. "Don't try to make it a personal exchange," she says.

• **Always document legibly.**

Lambert says case managers must document services in a legible fashion. This may seem obvious, but anything that cannot be deciphered is worthless, she warns. Likewise, anything that can be misinterpreted can leave a case manager exposed in a courtroom. If the documentation was sloppy, attorneys will argue that the care provided also was sloppy, she says.

• **Write things down promptly.**

Case managers should be diligent about taking contemporaneous notes, Lambert says. "You want to get it down as it happens or as close to when it happens as possible so that you don't increase your chance of error," she says. "If you put it off, you tend to forget it."

Even though case managers are busy juggling multiple responsibilities, they must be able to provide a paper trail that shows they covered every reasonable base and why treatment may have been adjusted, she explains.

• **Demonstrate that the physician is driving the care.**

Case managers should always demonstrate that the physician is driving the care, giving the orders, and leading the team. "You don't want anyone to misinterpret who is the lead dog," she asserts.

In short, she says, case managers should not overstep their boundaries. "The way to do that is to document that you are checking the orders and show how you are following through," Lambert says.

• **Stay abreast of case management.**

Case managers who stay up to date with developments in case management will fare much better than those who do not, she points out. Even the most responsible case manager probably will receive a complaint somewhere along the line, Lambert warns.

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How case managers can improve end-of-life care

Hospice care remains an untapped resource

End-of-life care is an area that, unfortunately, often is overlooked by much of the nation's health care system, including many case management departments, says **Sharon Mass**, LCSW, PhD, director of case management at Cedars-Sinai Medical Center in Los Angeles.

According to Mass, the goal of case managers should be to help terminally ill patients find comfort. She says that includes physical, psychological, social, and spiritual comfort. While crisis theory suggests that patients at this stage are highly vulnerable, they also tend to be very responsive, Mass says.

"We want to help people in terms of helping the process and the pathway of the rest of their life in a manner which allows them to integrate all of their experience through support," she says. "We all would like to experience 'a good death.'"

According to Mass, patients feel empowered when they are able to participate in their care. "There is no one right way to die." However, Mass says, case managers can use established frameworks to understand what patients value at the end of life. The alleviation of suffering and the physical symptoms of pain must be the critical component of a good death, she adds.

Mass points out that case managers often interact with patients who are still alert and able to express how they feel. "Sometimes that little sense of control being given back to the patient is very necessary," she says.

According to Mass, preparation for death means informing and educating both the patient and the family about what to expect. "It removes the fear of the unknown as much as one can when people know what the process is going to be and how we can help the patient," she explains.

All patients nearing end of life are faced with physical, psychological, social, and spiritual challenges, Mass notes. However, personal coping responses range from exceptional to adaptive to dysfunctional. "We need to gather as much information as we can so that we can strive for the goal of making the patient as comfortable as possible," she maintains.

According to Mass, that is the basic goal in working with end-of-life issues. "Sometimes, we don't take the time to do a thorough psychosocial assessment or to touch on the issues of what brings a person comfort or what brings a person hope or meaning in life," she explains. "An optimal treatment plan requires that we do that."

Emotional support is a significant component of discharge planning, Mass adds. "Wherever we can provide information that will help to prepare the patient, we are alleviating stress."

The first thing case managers can do is be knowledgeable clinicians, she says. "We need to know what the issues are, and we need to know what to be aware of when working with the terminally ill." Case managers also must communicate effectively as a representative, advocate, and liaison for the patient and family, Mass says. That includes negotiations with third-party payers, she adds.

Above all, case managers must learn to listen to the patient, Mass says. "Sometimes we forget to listen to the dying patients," she says. "If we don't talk to the patients about what is happening and give them the opportunity of choice, then we have not prepared them well."

According to Mass, hospice has much to offer dying patients and their families.

"Hospice is the best-kept secret in America," she argues. "We know that where patients have access to hospice and palliative care, we will have a better death for patients." Nearly 2 million people have been informed they have a life-threatening illness, yet only a fraction of those patients are referred to hospice, Mass says.

Last year, only 20% of terminally ill patients were seen by hospice. "That means 80% of the people who died did not have that opportunity," Mass says. Moreover, on average, patients are referred within 21 days of when they die. "We have three weeks to get everything done before they die," she says.

"Hospice in an undiscovered gem in Medicare," concurs **Jonathan Keyserling**, public policy vice president of the National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA.

"The Medicare hospice benefit is an unlimited, all-inclusive benefit," Keyserling says. "You have an all-inclusive philosophy of care that covers the physician, the nurse, a social worker, and a spiritual counselor, as well as all medical supplies, durable medical equipment, and prescription drugs related to the illness with almost no cost to the family under Medicare."

Recent statistics show that 775,000 patients and families were served by hospice last year, he says.

However, he agrees there is a shortfall in the number of people who are served, as well as the length of time they receive hospice services.

There is no simple explanation for this, because it would seem that both home care and hospital reimbursement mechanisms would encourage an earlier referral to hospice, he says. However, the perception often exists that hospice is only appropriate in the final weeks of life, he says. Only after exhausting any and all options, sometimes including futile treatment, is hospice usually considered, Keyserling adds.

According to Mass, physicians often resist the reality that patients are terminally ill. "It is very difficult to force health care professionals to look at death even though they see it every day and consider the possibility of having their patient die a good death," she explains.

Keyserling maintains that if the patient population was more aware of the care package that is available for hospice as well as the benefits to both the patient and family, hospice would be accessed much sooner. In fact, he says the most typical comment in response to surveys is that patients wish they had known about it sooner.

While 80% of hospice patients have a cancer diagnosis, Mass says there is a need for case managers to think about hospice for other patient populations.

Hospice presents case managers with an educational opportunity, Keyserling says. "I think it is incumbent on physicians and case managers to adequately explain what is available through hospice so that patients and families can make informed decisions about their treatment options."

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GUEST COLUMN

Use system analysis for lasting improvements

Questioning tools help find solutions

By **Patrice Spath**, RHIT
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In today's hectic health care environment, we tend to look for immediate solutions to problems. In our haste to "put out fires," we implement process changes that may offer immediate improvement; however, the problem that caused the fire often still exists. A more effective way to achieve lasting improvement is to use system analysis techniques when making a change in a process. System analysis involves interviewing process owners and management to gain a broader understanding of the problems so that better solutions can be developed.

The lack of a system approach by case management staff results in wasted troubleshooting efforts. Staff may not always comprehend the unique area of concern and the environment in which the process resides. That's why involving users and customers of the process is so important when solving problems.

Question those involved

A quick and effective questioning tool that can be applied in all environments consists of a series of six age-old questions: **why**, **what**, **where**, **who**, **when**, and **how**. Use these questions when interviewing and trying to understand an existing process or problem. Comments and insights from users can be elicited simply by asking:

- Why do we need this process / procedure?
- Why do we need this method?
- Why is this a problem?
- What is the purpose of this process / task?
- Where is this process done?
- Who does this process / task?
- When is it done?
- When does it have to be done?
- How is it accomplished?

Getting the answers to the why, what, where, who, when, and how and documenting the answers with flowcharts and narratives clarifies the process being studied.

Each question presents a different focus on the process because it requires the responder to further clarify the activities in another way.

Once a process is understood and defined,

(Continued on page 159)

Discharge Planning Advisor®

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DP staff feel the burden of prospective payment

Forms take more time, patients harder to place

Nursing facilities look at potential patients differently since the advent of Medicare's prospective payment system (PPS), a turn of events that those in the industry say has made discharge planning a more complex and time-consuming process.

More detailed and demanding screening assessments by nursing homes probably have increased the time discharge planners spend completing referral forms by 25% to 50%, says **Kathy Reilly,** RN, MS, A-CCC, CPUM, manager of resource management at MidState Medical Center in Meriden, CT.

Patients with a high cost of care — like those on total parenteral nutrition or expensive medications or who need high-tech durable medical equipment — are becoming more and more difficult to place, she adds.

Because nursing facilities are reimbursed according to the acuity of the patient rather than on a per diem rate, much effort must be spent documenting the factors that give evidence of that acuity, Reilly notes. If, for example, a patient has received intravenous (IV) medication within three to five days of admission to a nursing home, that treatment is reflected on the "minimum data set" (MDS), the patient acuity measurement tool that provides the medical information on which resource utilization groups (RUGs) categories are based. The RUGs category determines the amount of reimbursement.

Under the PPS system, Reilly notes, the number of minutes of therapy received per day gives the patient a different RUGs "score." The exact date a patient is taken off a ventilator after surgery must be noted because that, too, may put the case in a higher reimbursement category, she adds.

But while more acuity translates to more reimbursement, there is a point at which the payment tops out, so that nursing facilities can find themselves absorbing the extra cost of caring for the most acute patients, she says.

"These are the patients we see staying a little bit longer in hospitals, because they need to be more stable, and to receive less high-tech treatment modalities" before they can be placed in post-acute care, she points out.

"We have to know the facilities in our area that can and still do accommodate some of these higher-acuity patients. Some facilities have made the decision not to provide services for patients on ventilators or IV medication," Reilly says.

Screening assessment

Nursing homes, meanwhile, are calling on hospitals not only to give them the detailed information they need, but provide it in a more organized fashion, Reilly adds. Formerly the admissions director for a facility with 30 short-term rehabilitation beds and another 300 skilled nursing beds, she has seen the issue from both sides.

Although most hospitals have changed their referral forms to reflect the screening assessment the nursing homes use, a more standardized system is needed, she says.

"Having had experience at the nursing home dealing with multiple referral sources, I can tell you that if you look at the referral process at 30 different hospitals, there are probably 15 to 20 ways of doing it," Reilly says. "Some type of standardization might alleviate some of the problems."

It also would help remedy the situation if all nursing facilities would accept a "common nursing home application" from the hospital, she notes.

Although most accept the common form, Reilly adds, there still are some cases in which the family has to go to the facility in person to arrange a placement.

"It's more time-consuming and complicated, and it's a burden on patients' families," she points out.

The National Association of Subacute and Postacute Care (NASPAC) has developed a prescreening assessment tool for skilled nursing facilities (SNFs) that follows the language of the MDS and the PPS, notes **Diane Brown,** a member of the board of the Vienna, VA-based organization and president of JSC Inc., a Boston firm that specializes in education, consulting, and training for post-acute care. Although the form was designed for use by the SNF's nurse assessment coordinator, it would be "a marvelous tool for the discharge planner to use on the hospital side," Brown says. **(See related story, p. 157.)**

Another restriction on the discharge process is that managed care companies often have contracts with organizations that accept risk for some of the home health and nursing home placements, Reilly points out. That means another entity gets to weigh in on where the patient will receive care, she says. "That adds another layer to the complexity of discharge planning."

"[Discharge planning] is a very complex role," she says. "You can't just say, 'Here's the manual, go to it — identify the patients who need the complex planning.' There's not just a clinical perspective. You have to look at the psychosocial, the financial [factors]. They all affect the process rather dramatically."

The complexities of PPS can affect the patient's length of stay, Reilly notes.

"That's a negative financial impact, and it can be a negative clinical impact," she says. "We know that patients who stay in the hospital for a long time are at risk for certain infections, and hospitals are not in the business of being rehab facilities."

Working collaboratively with post-acute providers can help discharge planners identify early on some of the barriers to placement, she says. "You can also work with the physicians, suggesting that if it's clinically appropriate, we need to change this treatment modality because we can't provide it in this community."

Discharge issue part of bigger problem

An assessment of the PPS, conducted by the Office of the Inspector General's (OIG) Office of Evaluation and Inspection not long after the system's 1999 inception, found that nursing homes were changing their admissions practices in response to the new system.

About half of all discharge planners surveyed for the OIG report said that nursing homes were requesting more detailed information about the patient and were more consistently coming to the hospital to directly assess the patient before making admissions decisions.

When asked which types of patients had become more difficult to place, the majority of discharge planners identified patients who required extensive services, specifically mentioning those who need intravenous feeding, intravenous medication, tracheostomy care, or ventilator / respirator care.

That report, *Early Effects of PPS on Access to Skilled Nursing Facilities* (available at www.dhhs.gov), concluded that there was no direct evidence that Medicare patients were not receiving the SNF care they required.

The reason the complexity of the PPS system is coming to the forefront now as a problem for discharge planners, suggests veteran discharge planning and case management consultant **Jackie Birmingham**, RN, MS, CMAC, is that it's part of an overall problem with bed management.

"I think some nursing facilities started doing more scrutiny and calling the nursing units for more and more information, and I think this resulted in delays in discharge planning causing a backup of patients," says Birmingham, who is vice president of professional services for Curaspan Inc., a Newton, MA-based company that produces eDischarge, an on-line discharge system.

"It's probably one small part of the overall problem of bed capacity days," she adds. "Everyone is looking at ways to streamline the process now that there are internal (length of stay, bed capacity) and external (patient admission status and reimbursement case mix) pressures."

Electronic completion of forms can provide some relief for overburdened discharge planners, Birmingham says. "Filling out forms takes so much time. First you have to find the right form, then start it, and if anything changes for the patient, you have to start over. Electronic forms are easier to read, and there is speedier transmission."

Reilly's department has a patient transition coordinator who works with discharge planners, helping to facilitate the movement of communications with nursing homes, she says. Electronic forms would further smooth the process, Reilly agrees, "putting the professional doing the professional role."

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Will discharge planners take to NASPAC form?

Collaborative effort would be 'patient benefit'

A prescreening assessment form developed for skilled nursing facilities (SNFs) by the National Association of Subacute and Postacute Care (NASPAC) could be used collaboratively with discharge planners to provide the most appropriate care for patients, says **Diane Brown,** a member of the board of the Vienna, VA-based organization and president of JSC Inc., a Boston firm that specializes in education, consulting, and training for post-acute care.

But getting discharge planners to use the form — which gathers 108 pieces of information and requires two to three hours to complete — is "a hard sell," Brown adds. "[They think], 'Why should [I] use the tool and do all the work?'

The way the process typically works at present, Brown explains, is that a nurse assessment coordinator from the SNF goes to the hospital to physically examine the patient and gather the information before determining if the facility will accept the person.

However, at least one acute care provider — Yale New Haven (CT) Hospital — uses the tool to provide information for the SNFs in its catchment area, she points out. In that case, the SNF would send a person to the hospital to examine the patient only "if there's a very unusual case."

Discharge planners and nursing home staff completing and reviewing the form together would be "a marvelous patient benefit," says Brown, who helps develop the NASPAC curriculum and serves as an instructor for the organization. "We teach certification for nurse assessment coordinators, which is a two-day program, and we designed the tool to teach them how to do the process."

The tool uses the language of the minimum data set (MDS) and the prospective payment system, she notes, and is more extensive than most other forms. "Once [SNFs] accept a patient, they are legally responsible for that person. They are looking at a per-diem rate, and if the person is on an expensive medication they don't have, they may spend every bit of the [reimbursement] on medication."

"This is a useful tool to get everyone thinking about the functional needs of patients as they leave one setting and go to the next," Brown adds.

"The more you understand functionality, the better you are able to place the person appropriately," she says.

[For more information on the NASPAC prescreening assessment tool, contact the organization at (703) 790-8989 or Diane Brown at (888) 669-8123.] ■

Here's what's behind that thing you do

Discharge planning isn't optional, expert says

Discharge planning is the law. You knew that, right? Or maybe not.

Giving a presentation at a national meeting in Las Vegas recently on the rules and realities of discharge planning, veteran discharge planning and case management consultant **Jackie Birmingham,** RN, MS, CMAC, was shocked to discover that many in her audience did not know there were laws mandating discharge planning.

This was true even of those managing case management or discharge planning departments, notes Birmingham, who is vice president of professional services for Curaspan Inc., in Newton, MA.

What Birmingham came to realize, she says, is that this phenomenon was a function of the widespread hospital re-engineering efforts of the 1990s, during which many organizations decentralized services and laid off middle managers.

When hospital administrators noticed that the changes resulted in less desirable patient outcomes, including longer lengths of stay, they reestablished discharge planning departments, but put people in charge who had no discharge planning legacy, Birmingham explains. "So [the managers] are doing the right thing, but have no idea why they're doing it."

With that in mind, she has taken on the mission of disseminating information on the laws that

support discharge planning. The major impetus for discharge planning and case management, Birmingham notes, can be found in the following laws, which are listed with her interpretation of their provisions:

Social Security Act (SSA)

As stated in the Conditions of Participation for Hospitals (*Fed Reg* Dec. 19, 1997), the SSA makes a number of provisions regarding discharge planning. It directs health care providers to:

- Identify patients who need discharge planning.
- Provide an evaluation for patients.
- Evaluate patients on a timely basis to ensure appropriate plans.
- Include an evaluation of need for post-hospital services, including hospice.
- Include an evaluation in the medical record and discuss results with the patient and/or the patient's representative.
- Develop an initial implementation of the plan.
- Develop the plan under the supervision of a registered nurse, social worker, or other qualified person.

SSA Amendment (Utilization Review)

This amendment came about a few years after the establishment of Medicare sparked an increase in the usage of health care, Birmingham explains. "Utilization review was mandated because this was the first time there had been coverage for medical care and the utilization of services and the cost of the program were beyond what had been expected."

The government decided to start evaluating the quality and outcome of the services it was paying for to be sure there was appropriate care for patients, she adds.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

This act, which applies only to admitted patients, changed the way Medicare reimbursed hospitals, looking at groups of diagnoses and paying according to length of stay and cost per case, Birmingham says.

"That's when discharge planning became critical, because if hospitals began to discharge patients earlier, there needed to be a way to plan for patients who were leaving 'quicker and sicker.'" A process was needed to connect the post-acute providers with patients with more medical care needs, she adds.

Emergency Medical Treatment and Labor Act (EMTALA)

Passed in 1987, this legislation — often referred to as the "anti-patient dumping law" — specifies that a patient cannot be discharged or transferred from an emergency department until he or she is stabilized. "Stabilization," Birmingham points out, means that no significant medical deterioration is likely after the patient is discharged or transferred, and it is judged on professional standards of practice, not on the hospital standard.

A "nonstabilized" patient, she continues, may be transferred only when the medical benefits outweigh the risks, the patient (or family) consents, and there is medical treatment by the transferring hospital to minimize risk during transfer. The receiving hospital must agree to the transfer, all medical records must be sent, and the transfer must be accomplished with qualified personnel and equipment, Birmingham adds.

Preadmission Screening and Annual Resident Review (PASARR)

Another 1987 piece of legislation, the PASARR was passed to ensure that patients who have mental health needs are identified before admission to a nursing home, she says. It addresses the issue of whether patients being admitted to a skilled nursing facility have the medical/nursing needs to warrant the admission.

Medicare as Secondary Payer (MSP)

The MSP rules, passed in 1990, state that Medicare will not be the primary payer when another payer is available, such as when a patient's spouse is employed and has insurance coverage, when the treatment is the result of an automobile accident for which there is insurance coverage, or when workers' compensation applies.

Providers must review the MSP rules for every admission, as well as for outpatient cases and laboratory tests, Birmingham notes. Hospitals are liable for recovery of money for up to 10 years after the admission or service.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This legislation, for which regulations are still being written, burdens discharge planners with needing to know as much about laws as they do about diseases, Birmingham says.

The privacy section of HIPAA will affect how referrals are made and how information about patients is transferred from one level of care to another, as well as what will need to be documented even about referral sources that don't take the patient, she adds.

Discharge planners should be aware of the regulations on privacy as if their license depends on it, Birmingham warns. ■

(Continued from page 150)

another series of questions can be used to determine if the current process steps are really necessary. This is done by looking at each component of the process narrative and flowchart and asking: Can this task be eliminated? Changed? Combined? Simplified? Asking for improvement recommendations can be a very powerful and insightful question. Often the answers are in front of us. We just need to solicit input from those closest to the process. By asking users and those ultimately responsible for the process for their thoughts and recommendations, a list of alternative solutions can be compiled. This step is an important way of getting everyone involved in the solution process by having their ideas solicited and considered. Users of the process will have more accountability if their ideas are accepted.

When putting together a clear understanding of the problem, other data-gathering strategies may be needed to complement the questioning technique. One form of data gathering is observation. Observing a process in the user's own environment, or getting a demonstration of the process or problem, combined with asking the aforementioned questions, provides valuable insights. Visit the area where the process is done and experience what people see and feel. Surveys also can reveal issues that might not be uncovered any other way. A person completing a brief, five-minute survey may disclose problems, issues, processes, or solutions not found through other data-gathering techniques.

Questioning and other data-gathering techniques provide an opportunity to continually ask questions until the problem is defined from all perspectives — process owners, management, and others impacted. And with each technique, don't forget to ask, "What do you recommend?"

Case management application

The following case study illustrates the use of system analysis to improve a process involving case managers. The director of case management believes that case managers are not receiving timely notification of new inpatient admissions that would benefit from case management services. In some instances, case managers are not contacted until the patient is less than 24 hours away from discharge. There appears to be a breakdown in communication between the staff nurse who conducts the patient's admission assessment and the case management department. System analysis techniques are used to help define and resolve the problem.

First, the present system of assessment and communication is defined. By interviewing staff nurses, supervisors, and case managers from different units, an understanding of the current process is developed. Asking, "Why should patients needing case management services be identified at the time of admission?" documents the need for the process. The question, "What is happening?" gets to the current method for assessing

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Editorial Questions

For questions or comments, call **Russ Underwood** at (404) 262-5521.

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THOMSON
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patients and communicating results to case managers. Asking, "Where it is happening?" allow people to define and understand the location and its limitations. Asking, "Who is doing it?" documents the staff doing the initial patient assessments. The question, "When does the process occur?" focuses thinking on day of the week and time of day. Asking, "How is communication between the admitting nurse and the case manager actually done?" documents the information exchange as it now exists. Answers to the above questions are documented in a flowchart showing the present admission assessment and case manager communication process. This draft document is then reviewed with those interviewed to elicit feedback and clarification.

The next step is to look at the current process to determine where improvement can be made. Can a step be eliminated? For example, is it really necessary for the nurse to complete a separate form to request a case manager consultation? Can something be changed? For example, can elective admissions be screened prior to admission to identify those needing case manager services? Can something be combined? For example, can case managers be present during the initial nursing assessment? All questions are designed to determine if a step can be eliminated or streamlined.

As people brainstorm ways to improve the process, a unit secretary who has been asked for an opinion and recommendation responds with, "We see many of the same patients over and over again. Why not set up automatic case management referrals for these patients?" A staff nurse builds on this answer by suggesting that the admissions department directly notify case managers when previously admitted patients with chronic conditions are readmitted. A physician offers an additional recommendation: "Let the patient's family contact the case management department directly when care coordination issues arise."

When everyone involved in a process is brought together in a room to solve a problem, they often become engaged in a chaotic and unstructured discussion of quick-fix solutions. Using system analysis techniques, the leader of the discussion can focus people on what is needed to achieve lasting results. The asking of why, what, where, who, when, and how provides problem solvers with a structure for achieving the best solutions.

Questioning whether process tasks can be eliminated, combined, changed, or simplified further defines the process and can lead to a more efficient process. The question, "what do you recommend?" recognizes that those closest to a process often have the solution.

These questions lead to a better understanding of the system or problem so that the best options and solutions can be defined. ■

CE objectives

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

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■

CRITICAL PATH NETWORK™

Assessing trauma patients boosts efficiency

When a 3-year-old boy was transferred to Eastern Maine Medical Center (EMMC) in Bangor, emergency department (ED) staff were told he was stable.

However, when the boy was given a score according to the hospital's "trauma tier" pre-hospital triage system, it became clear the injuries were much more severe than anticipated.

Originally, the plan was to admit the child directly to the medical floor, but instead he went straight to the operating room for emergency surgery to remove a ruptured spleen, says **Erik N. Steele**, DO, ABFP, the facility's administrator for emergency and trauma services.

Steele explains that the ED uses a unique pre-hospital assessment process to gauge the severity of trauma patients' injuries before they get to the ED and to predict what level of response is needed.

"This helps us identify patients who are actually sicker than they are described to us, either because there were injuries that were not recognized, or because the patient's condition deteriorated on the way here," he says.

Patients are given a score of Tier One, Two, or Three, so that the hospital's trauma response is in place before the patient arrives, he explains. A hospital committee developed the tier system based on Maine's existing pre-hospital triage system.

"We can score the patient in a matter of seconds using our triage form," Steele says. **(See EMMC Emergency Services Trauma Triage Worksheet and chart on staff called in for each tier, pp. 152-153.)**

Here are benefits of the trauma tier scoring system:

- **Resources are used more efficiently.**

Steele notes that previously, the hospital's trauma team was mobilized for trauma cases, although they were not needed for the vast majority.

"This tool will help you determine what kind of patient you are getting, so you can match up the response to the patient," he says. For example, the scoring system reliably predicts which patients will require a bed in the intensive care unit (ICU), an operating room, or surgeon, he says.

He says this system would allow smaller EDs without in-house residents and other surgeons to avoid overcommitting limited resources.

"For a rural ED, calling up a trauma response means calling nurses, surgeons, and anesthesiologists in from home," Steele notes. "If you can do that only when a reliable system suggests you should, you can use those precious resources appropriately."

For instance, data have shown that 82% of the Tier One (most severe) trauma patients will go to the ICU or die in the ED. Based on that statistic, an accurate prediction can be made as to what resources, such as an ICU bed or respiratory therapy, will be needed, Steele says.

A smaller ED might use this to predict who is going to be transferred, he suggests, so that that process can be started.

Previously, Steele says, the team was not called in until the patient arrived. "That means that with severely injured patients, there is a chance that you won't have the team there when you need them. Or you will overcorrect and call in the team every single time, in which case they will come in lots of times and be sitting around." That process is costly and hard on the call teams, he adds.

(Continued on page 154)

EMMC EMERGENCY SERVICES
TRAUMA TRIAGE WORKSHEET

PART 1: Assess **PHYSIOLOGIC DYSFUNCTION** via RTS or PTS
(Circle applicable findings and add total points)

AGE >14 years or best guess

REVISED TRAUMA SCORE	+4	+3	+2	+1
RESPIRATORY RATE	10-29	>29	6-9	<6
SYSTOLIC B/P	>89	76-89	50-75	<50
GCS	13-15	9-12	6-8	<6

TOTAL

AGE <15 years or best guess

PEDIATRIC TRAUMA SCORE	+2	+1	-1
WEIGHT	>44 lb. (>20 kg)	22-44 lb. (10-20 kg)	<22 lb. (<10 kg)
AIRWAY	Normal	Oral or Nasal Airway	Intubation or Cricothyrotomy
CIRCULATION	Radial Pulse Present (B/P >90 Systolic)	Femoral Pulse Present (B/P 50-90 Systolic)	Absent Pulse (B/P <50 Systolic)
LEVEL OF CONSCIOUSNESS	Awake, alert	Any alteration of consciousness	Unresponsive
OPEN WOUNDS	None	Minor	Major or Penetrating
FRACTURES	None	Single, Simple	Open or Multiple

TOTAL

PART 2: Assess for **ANATOMIC COMPROMISE**. Check any that apply:

- ☐ PARALYSIS
- ☐ AMPUTATION ABOVE WRIST OR ANKLE
- ☐ PENETRATING INJURY TO HEAD, NECK OR TRUNK
- ☐ TWO OR MORE PROXIMAL LONG BONE FRACTURES
- ☐ UNSTABLE PELVIC FRACTURE
- ☐ OPEN OR DEPRESSED SKULL FRACTURE
- ☐ BURN, ASSOCIATED WITH TRAUMA

PART 3: Assess for **EVIDENCE OF HIGH-ENERGY TRANSFER (KINEMATICS)**:

- ☐ IN MVA: DEATH OF OTHER OCCUPANT OF SAME VEHICLE COMPARTMENT

DETERMINE A TIER OF RESPONSE

RTS < 9 or PTS < 7	RTS = 9 or 10, PTS = 7 or 8 *OR* Any ✓'s in parts 2 or 3	ALL OTHERS
TIER **ONE**	*TIER* **TWO**	*TIER* **THREE**

Source: Eastern Maine Medical Center, Bangor.

Here are staffing needs for trauma patients

Here are the minimum personnel mobilized for each category of trauma patients arriving at Eastern Maine Medical Center in Bangor, according to the hospital's Trauma Tier prehospital triage system:

	Tier One	Tier Two	Tier Three
Operational theme; system expectations	• Immediately life-threatening; obvious instability. Anticipate need for *resuscitation* in trauma room or OR. • Anticipate need for operative interventions as part of acute management. • Maximum ED, institutional, and medical staff response.	• Potentially life-threatening. • Anticipate need for *stabilization* in trauma room or OR. • Maximum ED response, intermediate institutional and medical staff response.	• No evident instability. • Standard operational procedure.
Personnel minimums[1]	1. Page trauma surgeon STAT (with adequate notification, presence on or prior to patient arrival may be anticipated). 2. ED physician 3. Anesthesiologist or Certified Registered Nurse Anesthetist 4. Primary Nurse[2] 5. Resource Nurse 6. Recorder[3] 7. X-ray technologist (If multiple patients are anticipated to require X-rays, request backup technologist) 8. Lab phlebotomist 9. Respiratory therapist 10. Social worker or chaplain[4] 11. Page neurologic or orthopedic surgeon following initial assessment, for any applicable injuries 12. Page other physician specialists at the discretion of the physician of record	1. Page Trauma Surgeon ASAP, for phone consultation with ED physician and response as needed. Presence may be anticipated within 30 minutes of patient arrival. 2. ED physician 3. Anesthesiologist or certified registered nurse anesthetist (At request of ED physician or or trauma surgeon) 4. Primary nurse[2] 5. Resource nurse 6. Recorder[3] 7. X-ray technologist 8. Lab phlebotomist 9. Respiratory therapist[5]	1. Primary Nurse[2] 2. ED clinician ASAP

1. Until accused by either primary nurse or physician of record. Each role described must be assumed by a separate person.
2. Must be certified in a comprehensive trauma curriculum approved by the ED nurse manager (e.g., trauma nursing core course)
3. If not an ED nurse, must have a working familiarity with ED trauma documentation standards.
4. Summoned at the request of charge nurse or designee following contact (or lack thereof) with significant others. Consider critical incident stress debriefing for staff members.
5. As needed for mechanical ventilation or blood gas sampling.

Source: Excerpt from *Appendix D: Review and Overview of the Trauma Tiers*, Eastern Maine Medical Center, Bangor.

(Continued from page 151)

A trauma team is a significant dedication of resources, notes **Pret Bjorn**, the facility's trauma coordinator.

"If you call in the trauma team every time you hear the screech of tires on the road, you are not going to create a system that endorses itself to surgeons or administration," Bjorn says.

• Relationships with on-call physicians are improved.

Before the tier system was implemented, Steele reports that there were problems with on-call physicians who thought the ED called them needlessly. The system allows the ED to predict which patients need a general surgeon immediately, and which of those need the general surgeon within 30 minutes, he says.

"In exchange for calling only when we need them, they always come in, and there is no argument," he says. "The surgeons are pretty much guaranteed to get sick patients if they respond to a trauma page."

Only for a very small group of patients is the on-call physician required to drop everything and come to the ED, Steele says.

"For a slightly larger group, they will need to come within 30 minutes. And for about 80% of the population, we don't call until we've assessed the patient, which means they may not even hear from us," he explains.

The goal is to avoid a knee-jerk response based on unscientific information, Bjorn says. "The goal is to cooperate with general surgeons and make life reasonable for them," he underscores.

Frequently, victims of motor vehicle crashes arrive largely uninjured and won't require the general surgeon immediately, at least, Bjorn notes.

"It only takes three or four times of calling in the surgeon when the patient is fine before they are reluctant to come in next time you call," he says.

[For more information about the preassessment system for trauma patients, contact:

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CE questions

13. With its emergency department case managers, Saint Vincents Hospital and Medical Center has managed to reduce which of the following?
    A. length of stay
    B. social admissions
    C. CHF readmissions
    D. all of the above

14. Which of the following are steps case managers can take to protect themselves and their hospitals from legal liability, according to Kathleen Lambert, JD, RN?
    A. Stay within the standards of care.
    B. Always document legibly.
    C. Demonstrate that the physician is driving the care.
    D. all of the above

15. According to Jonathan Keyserling, public policy vice president of the National Hospice and Palliative Care Organization, how many patients and families were served by hospice last year?
    A. 255,000
    B. 525,000
    C. 775,000
    D. 1,025,000

16. According to Patrice Spath, RHIT, system analysis involves interviewing process owners and management to gain a broader understanding of the problems so that better solutions can be developed.
    A. true
    B. false

Answers: 13. B; 14. D; 15. C; 16. A