HOSPITAL CASE MANAGEMENT™

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

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IN THIS ISSUE

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Stop inappropriate admissions to improve your hospital's patient flow

Emergency department case managers are a key

With today's shrinking health care dollars and pressure from payers to move patients through the continuum faster than ever, hospitals need to focus on improving patient flow. That's where case managers come in.

"By stopping inappropriate admissions, the case manager really facilitates patient flow. In addition to opening a bed for another patient who needs it, the case manager is preventing utilization of resources for a patient who doesn't need it and optimizing patient safety by not exposing patients to potential infections," says **Toni Cesta**, RN, PhD, FAAN, vice president, patient flow optimization for the North Shore-Long Island Jewish Health System and health care consultant and partner in Case Management Concepts LLC.

Increasing efficiency

Numerous studies have shown that once a hospital reaches a 90% occupancy rate, internal resources tend to slow down, she adds.

"Staff and services don't increase because of higher capacity. When a hospital reaches a high occupancy rate, it still has the same number of stress test machines and the same number of physical therapists. Patients tend to wait longer for services, and the length of stay can go up accordingly," Cesta says.

If case managers can help keep inappropriate patients out of beds, the hospital services will be more efficient and quality of care will increase, she adds.

A multitude of issues affect patient flow, adds **Brenda Keeling**, RN, CPHQ, CPUR, president and owner of Patient Response, a Milburn, OK, health care consulting firm.

Patients come into the hospital at numerous entry points — the ED,

cardiac catheterization, the post-anesthesia care unit, the outpatient unit, and as direct admissions from physician offices, she says.

The traditional practice of having case managers see patients within 24 hours of admission doesn't work well in today's health care environment, Keeling points out.

"Case managers need to review the cases before any admission is accepted to determine that the admission is appropriate and meets medical necessity, and if it doesn't, to query the physician at that time and not three days later," Keeling says.

Although people think that discharge planning should be the main focus of case managers when it comes to improving patient flow, discharge planning actually is the tail end of the process, Cesta adds.

"Case management is a combination of utilization management, care coordination, and discharge planning, all wrapped into one. If case managers are doing all their other tasks well, discharge planning will fall in line with the other processes," she says.

Hospitals need case managers on the front end to make sure things go faster on the back end, and that means that emergency department case management is an essential part of the patient flow process, Cesta says.

"Case managers in the emergency department can keep inappropriate patients out of acute care beds and make sure that the charts of patients who meet criteria are documented properly," she adds.

She recommends having case managers in the emergency department who review the medical record after the emergency department physician has issued the order to admit but before the chart is processed.

"Maybe the patient is clinically ill but the documentation doesn't support it, or maybe the patient can go home with home care or is appropriate for admission to a lower level of care," she says.

Suggestions on implementing CMs in the ED

Cesta suggests having RN case managers cover the emergency department for a minimum of 12 hours a day, with additional coverage by social workers. It takes 2.5 FTEs for case management coverage, 12 hours a day, seven days a week, she says.

"Case managers and social workers in the emergency department should work together in a way that is similar to the inpatient case management model," she says.

Nurse case managers should work closely with the social workers to ensure that all patients' needs are met and all the issues are resolved, she says.

The nurse case managers should cover clinical throughput and utilization and potential discharges, while the social workers concentrate on psychosocial issues that may have caused the patient to come to the emergency department or

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prevent the patient from being safely discharged.

Plan emergency department case management coverage around high-traffic times, typically from 10 a.m. to 10 p.m. or 11 a.m. to 11 p.m., with the social workers coming in earlier in the morning, she says.

"Ambulances come in whenever there is an emergency, and there is no pattern. The way to determine the best hours for coverage is to look at when patients either walk in or come from the physicians' office. Patients don't typically walk into an emergency department in the middle of the night," she says.

The walk-ins are likely to be the softest admissions and the patients who would greatly benefit from not being admitted to the hospital and, therefore, should get the most attention from case managers, she says.

Watch for patterns

Look for patterns around the diagnoses of patients whose stay is denied.

"It's not always the short-stay patients whose stay is denied. Once they get admitted, patients who do not meet admission criteria may stay for several days," she says.

Many times, it's the soft-admission diagnoses that are denied, Cesta says. Typical diagnoses include chest pain, dehydration, mild head trauma, and syncope.

Aggregate data to determine if there is a particular physician or a particular diagnosis that most frequently is involved in denials and focus on those, she adds.

"One person can't follow every case in a busy emergency department. Case managers need to prioritize which cases to review," she says.

When patients get to the floor, case managers should be coordinating care for the patients so each day is optimized.

"Typically, the role of the case manager is to ensure that patients are getting services in a timely fashion and that they continue to meet criteria for the acute level of care," Cesta says.

An active physician advisor can be a tremendous help with moving patients through the continuum and getting them discharged in a timely manner, Keeling says.

"In most hospitals, case managers can justify having a full-time physician advisor if they show documented evidence from a financial aspect that they are needed," she says

Patients should be discharged from the hospital when they are clinically ready, no matter what time of day it is, Cesta says.

"The plan to discharge all patients by 11 a.m. has never worked. Nobody has been able to do it consistently. All patients aren't ready to march out the door at the same time," she adds.

If all patients leave at the same time, it will affect the admitting process, as the admissions office struggles to fill the beds with patients who have been waiting. This, in turn, affects ancillary services because there is an influx of people needing services, she adds.

"Batching all the work — discharges and admissions — is anti-patient flow. Spreading the discharges spreads the resources associated with admitting," she says.

Patient flow is stymied when hospitals don't anticipate discharges, Cesta says.

"Hospitals don't do well at planning discharges in advance. They often wait until the doctor comes in and issues the discharge order. If you anticipate the discharge the day before, it improves patient flow considerably," she says.

For instance, if a case manager orders transportation to transfer a patient to a skilled nursing facility the day before, the ambulance is likely to arrive within a 15-minute window. If he or she waits until the day of the admission, wait time may be four hours or more.

"If a patient is likely to be discharged tomorrow, the family should be told today so they can prepare," Cesta says.

Using the IM

Use the issuance of the Important Message from Medicare to trigger your advance discharge planning, Cesta says.

When you issue the Important Message, activate the discharge plan. Notify the family, ensure that the patient has the prescriptions he or she needs, and arrange for home health or transportation.

"This strategy works much better than last-minute reactions," she says.

Discharge lounges for patients who are ready for discharge but whose families can't pick them up until later work well at some hospitals. They require additional resources, including a nurse to provide medications and food services.

Hospitals are going to have to move to providing services seven days a week to achieve optimum patient flow, Cesta says.

"Patients who come in on Friday are typically going to be there until Monday, and all that

expensive equipment is going to languish. Then, when the hospital ancillary departments ramp up on Monday, there is a backlog of people who were waiting for tests and procedures all weekend," she adds.

(For more information, contact ***Toni Cesta,*** *RN, PhD, FAAN, vice president, patient flow optimization for the North Shore-Long Island Jewish Health System, e-mail: tcesta@lij.edu;* ***Brenda Keeling****, RN, CPHQ, CPUR, president and owner, Patient Response, e-mail: brenda@ patient-response.com.)* ■

Compile data to make your case to administration

Show CMs affect patient flow, bottom line

It will take well-organized data to show your hospital administration how case managers can affect patient flow and to justify additional staff to focus on the effort, says **Toni Cesta**, RN, PhD, FAAN, vice president, patient flow optimization for the North Shore-Long Island Jewish Health System and health care consultant and partner in Case Management Concepts LLC.

"Data can be very compelling, but they have to be presented to the administration in a form they can relate to," she adds.

The most important thing that case managers can do to improve patient flow is to track and trend the barriers to moving patients through the hospital and implement performance improvement initiatives, adds **Brenda Keeling**, RN, CPHQ, CPUR, president and owner of Patient Response, a Milburn, OK, health care consulting firm.

This may mean putting case managers in the emergency department, increasing the hours that case managers cover the hospital, or hiring a full-time physician advisor to assist case management, she adds.

"The average cost for a patient day is about $1,200. Inappropriate admissions for which payment is denied or patient days that are denied because they no longer meet medical necessity can get costly for hospitals. If you can show how case managers can help avoid the denials, you can make your case," Keeling says.

Cesta worked with one hospital to conduct a retrospective analysis of patients who were admitted through the emergency department and whose entire stay was denied because they didn't meet admission criteria.

$3 million opportunity

The analysis revealed a $3 million annual opportunity to increase reimbursement by developing a process to ensure that patients admitted through the emergency department meet criteria.

Start by compiling information on admission denials — patients who were admitted but the hospital received no payment for the stay — Cesta recommends.

Drill down to find the reasons for the denial and how the patients were admitted in the first place.

Determine the average length of stay for patients whose stay was denied. Then tabulate the cost to the hospital for the denied care, which translates to how much money the hospital would have saved if the patient had been placed in observation or evaluated and sent home.

"Not only does the hospital lose money when the admission is denied, they take up a bed that could be occupied by patients whose cost of care would be reimbursed," Cesta says.

Look for the root cause

Look at your hospital's busiest times and determine how many hours the emergency department was on diversion and how many patients were admitted who were more appropriate for outpatient services, skilled nursing, or rehabilitation, Keeling suggests.

Look for the root cause for denials: Is it one specific carrier, one provider, one department, floor, or one case manager? And do a cost-benefit analysis of the financial side of impeded patient flow, she adds.

"Case managers tend to deal with denials from insurance companies because they know that's where the hospital's income is coming from, but they don't look at why there are denials," Keeling says.

Determine the reasons for denied days and attach a dollar figure to each cause, she suggests. Present the data in an informative manner, using charts and graphs, rather than anecdotal information, Keeling adds.

"People can instantly understand visual presentations. Showing a chart is far more effective than making a long, verbal presentation," she adds.

Use the data to make your case for more staff or for having a full-time physician advisor, Keeling says.

Physician advisor case

"A lot of hospitals don't have a physician advisor, or they have someone who works only part time. Case managers have to show how the physician advisor can help with throughput by intervening when a physician insists on admitting a patient who doesn't meet criteria or when discharges are stalled," she says.

If you have a part-time physician advisor, track the times that he or she intervened with the admitting physician and resolved the issue for the case manager.

Collect all the other potentially avoidable days and show how much it would have saved the hospital if there had been a physician advisor to intervene on just a percentage of them, she adds.

For instance, a patient is admitted with a high fever and put on IV antibiotics. The insurance company denies coverage for the last two days of care because the patient could have been converted to oral antibiotics and sent home.

"The case manager can document that he or she was unsuccessful in persuading the attending physician to send the patient home and show that if there had been a physician advisor to discuss the situation with the attending, the denial could have been avoided, saving the hospital a minimum of $2,400," she says.

Your data also can be used to gain support from the administration in dealing with issues that impede patient flow, she suggests.

For instance, the administration may not listen if you talk about how you can't get Dr. Smith to discharge his patients in a timely manner, but if you can present data that show that 80% of denials are Dr. Smith's patients, the administration will take notice.

"The administration has to have data in order to go head-to-head with a physician, particularly if he or she is one of the top admitters," she says.

In another scenario, if a piece of equipment, such as a CT scan machine, was broken, look at how many days were denied because patients were waiting for the service and add up the cost.

"The administration may think it would be expensive to get the machine fixed, but when that's compared with the cost of a lot of patients staying extra days, it's a bargain and it improves patient flow," she says. ■

Innovations help medical center keep LOS low

CMs assign DRG, follow patients through stay

When patients are admitted to Alamance Regional Medical Center in Burlington, NC, care managers are responsible for assigning the DRG and length of stay and establishing medical necessity and the correct patient status.

After admission, one care manager follows the patient throughout the hospital stay and is responsible for care coordination, utilization management, and discharge planning from the beginning of the stay until after discharge.

For instance, a case manager who covers the orthopedic DRGs meets the patient while he or she is in a joint class prior to admission, then follows the patient to the medical floor after surgery. The same case manager places the patient in a rehabilitation unit or facilitates home services the patient will need after discharge.

Having one person track the patient throughout the stay has increased efficiency, assured continuity of care, and improved the discharge planning process. The efficiency helps the 238-bed regional hospital maintain an average length of stay of 4.1 days, says **Beve Butler Smith**, RN, MSN, CHCC, director of care management.

"Patient stays on the oncology unit can often drive the length of stay up but we have continued to move other patients safely through the continuum and keep length of stay low. Our length of stay is consistently under budget," she adds.

Assigning duties

The hospital leadership made the decision to have case managers assign DRGs 4½ years ago, and leaders integrated case management, utilization management, discharge planning, and social work at the same time.

"The idea was to increase staff satisfaction, provide equity among the case managers who are social workers and registered nurses, and increase efficiency for better patient throughput," Smith says.

At the same time, the leadership created a career ladder that includes four levels of achievement and allows care managers to be promoted based on education, experience, productivity, and performance.

"The dynamics of case management have changed tremendously in recent years. We used to deal primarily with length of stay. Now, we look at whether or not the patient's condition qualifies to be a medically necessary admission, what status they must be in, and we constantly monitor delay-of-care issues. We often have to pull a rabbit out of a hat to find a safe place for a homeless patient or medications and other services for the underinsured. Now, it is everyday work to meet the challenges that used to happen only occasionally," Smith says.

The hospital's medical records are completely electronic, which makes patient progress easily accessible on interdisciplinary screens that include clinical summaries, documentation, consultations, and discharge planning steps.

"This makes the work of the care manager much faster, as communication with all the other disciplines is now quicker and more efficient," Smith says.

DRG & InterQual training

The care managers have received extensive training on the use of InterQual criteria and the MS-DRG system and were cross-trained so they can perform those duties as well as utilization review and discharge planning. They have an average caseload of 15-16 patients.

Before the reorganization, the RNs were in charge of utilization review and social workers handled discharge planning.

"The separation of functions created poor communication within the team, and the silo effect was pronounced. The primary motive for the change is good continuity of care. Only one person accesses the medical records, spends time gathering information about the patient's insurance, monitors the care the patient is receiving, and is aware and involved in the family dynamics and discharge needs. This makes it much easier to develop patient rapport and to ensure that the patient gets the services he or she needs after discharge. Now the physician knows who to talk to about each patient," Smith says.

The patients and family members appreciate having just one care manager they can call on with questions and concerns throughout the hospital stay. Often the patient requests the same care manager if he or she is hospitalized again.

In addition to the hospital's contract with a patient satisfaction firm, the care management department conducts its own patient satisfaction survey and consistently scores 95% or better on satisfaction, she says.

"We also survey the physicians and ask how we are doing twice a year. The results are positive. One physician wrote, 'Our care managers rock!'" Smith says.

"We staff the emergency department every day from 7 a.m. to midnight, seven days a week, to stay ahead of all the regulations and keep the length of stay down," she says.

When an emergency department physician issues the order to admit a patient, the case is referred to the emergency department case manager. The care manager reviews all admissions to determine if they meet InterQual criteria for an acute care admission and to ensure that the patient is placed in the correct status. All admissions — from the cancer center, post-anesthesia care unit following same-day surgery, and direct admissions from physicians' offices — also are assessed by a care manager.

"If we are not able to satisfy medical necessity criteria, we go back to the physician and ask for more documentation. If there isn't additional information to change it and it's a Medicare patient, we issue the Medicare HINN letter, informing the patient that they could be responsible for payment," she says.

The case management department has two physician advisors that the care managers can call on during regular hours if they have questions about whether a patient meets medical necessity for an admission or for a continued stay.

The hospital also has a contract with an outside physician agency that care managers can call to review the cases any time of the day or night, seven days a week.

When there is a secondary review, the physician reviewer writes a compliance letter that is scanned into the patient's medical record.

"We use the compliance letter very successfully in denials or appeals and will have it on file as a secondary level of defense when the Recovery Audit Contractor program begins," Smith says.

When the emergency department case managers have assigned the MS-DRG, the electronic medical record automatically refers the case to the care manager who is coordinating care for that kind of patient. The primary admission review is completed by the admitting care manager and is a permanent document in the electronic medical record.

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CRITICAL PATH NETWORK™

CM protocol results in decreased denials

Physicians delegate patient status determination to CMs

Payer denials for inappropriate observation patient status dropped by 50% the first year after Good Samaritan Hospital in Dayton, OH, instituted a case management protocol that delegates responsibility for determining patient status to case managers.

The protocol was developed by the multidisciplinary integrated care management status team, which worked closely with Ohio KePro, the hospital's quality improvement organization, and was approved by the hospital's medical executive committee. **(For details on how the protocol was developed, see related article on p. 9.)**

The hospital is licensed for 577 beds and has an occupancy rate of about 73%. The case managers are unit-based and have an average caseload of up to 25 patients a day.

The hospital piloted the protocol in the ED, where the majority of patients are admitted, beginning in May 2007, and rolled it out throughout the hospital a year later, says **Teresa I. Gonzalvo**, RN, MPA, CPHQ, LNC, director of integrated care management.

"About 70% of admissions come through the emergency department, and therefore, that department has the most status assignments. We decided to roll the process out in the rest of the hospital after we piloted it in the emergency department because of the size and number of services. We had many access points and many dissimilar processes and had to come up with a way to make it work," Gonzalvo says.

At Good Samaritan, all admitted patients are reviewed by a case manager for admission status, regardless of their access point or payer, she reports.

The case managers use InterQual criteria and Medicare guidelines for medical necessity as the basis for determining whether the patient will be in observation or inpatient status. CMs are responsible for assuring the correct status from admission through discharge.

The admission status of patients admitted through the ED is determined by case managers who cover the department 24 hours a day, seven days a week.

When patients who come to the hospital at other access points get to the floor, their admission status is determined by the case managers on the floor who work from 8 a.m. to 4:30 p.m., Monday through Friday. After hours and on nights, weekends, and holidays, the ED case managers review the admissions of patients admitted at all access points and ensure that their status is correct, Gonzalvo says.

Before the protocol was implemented, two case managers covered the ED for 12 hours a day, Monday through Friday.

Adding FTEs to ED

The hospital committed an additional 4.3 FTEs to provide case management support in the ED around the clock.

Since the protocol was implemented, there has been a significant increase in the ratio of patients admitted to inpatient status, rather than being in observation, says **Donald P. Sickler**, MD, medical director, integrated care management.

Having 24-7 coverage in the ED was essential to the success of the protocol, Gonzalvo adds.

"When we didn't have staffing on certain

nights, the case managers would have to review admissions from the previous night along with surgical admissions and were always behind in their work," she says.

The hospital's ED bed request form includes a section for the case manager to assign the patient to observation or inpatient status and sign and date it. The form is not part of the permanent record.

Case managers also fill out a case management status sheet, which includes the date and time the patient is placed in inpatient or observation status and check-off boxes for the rationale for the status assignment. The sheet is signed by the case manager and placed in the medical record. If the status changes, the case manager fills out a second sheet and puts it in the record.

If the attending or admitting physician disagrees with the status determination, the case manager discusses the disagreement with the admitting physician and, if there is no resolution, refers the case to the medical director or the vice president of medical affairs. If there still is disagreement, the final determination is made by two physician members of the hospital's utilization review committee as specified by Centers for Medicare & Medicaid Services guidelines.

As physician advisor to integrated care management, Sickler makes daily rounds with the case manager on each unit, including the ED. He discusses cases with them and mediates when there is a disagreement with the medical staff. He is available by pager throughout the day.

If the ED case managers have questions about a difficult case when Sickler is not available, they call the integrated case management manager or director and, if it's still a gray area, assign a default observation status to the care. The situation is discussed with Sickler or the vice president of medical affairs as soon as possible.

On weekends, nights, and holidays, the emergency department case manager runs a report of observation cases, and then reviews the charts of the new admissions, and ensures that the patient is assigned the right status.

"The case managers can assign the correct status or have a conversation with the admitting physician to determine what the disposition should be, based on medical necessity," says **John W. Clark**, BN, BSN, manager, case management.

Having someone review patient status on weekends is critical to ensure that those patients in observation who now meet inpatient criteria are placed in the appropriate status, Gonzalvo says.

"A patient admitted on the weekend may initially be appropriate for observation but may need to be converted to inpatient status. If someone doesn't make sure the status remains appropriate, we end up with two days of observation for someone who should have been an inpatient," Gonzalvo says.

The team created a user-friendly manual for Medicare's inpatient-only list to ensure that patients who receive surgical procedures on the list are admitted to the hospital as inpatients.

Surgery schedules also use the manual to determine if patients should be admitted as inpatients. The case managers re-evaluate patient status while patients are in the recovery room.

Unit-based CMs manage post-surgery patients

The unit-based case managers take turns rotating through the post-anesthesia care unit to determine admission status for patients who are in recovery following surgery. If the unit that's assigned recovery room responsibility has a big caseload on its regular unit that particular day, another unit takes over the process.

"It's easier to get these patients admitted in the right status if someone goes to the recovery area, rather than trying to manage the admission status when the patients get to the floor," Clark says.

In isolated cases, when a case manager doesn't see a patient within 16 hours of admission, the patient status defaults to observation. Then the case manager can review the chart and continue the status as observation or assign the status as inpatient if appropriate.

"This gives us up to 16 hours after admission to make the initial status determination. Since we have case managers in the emergency department 24-7, a default status happens very rarely, if at all," Gonzalvo says.

The case manager can convert the defaulted observation status to inpatient by the case management protocol at the time the need for acute inpatient level of care is determined, she adds.

One challenge is patients who must have a three-night stay to qualify for Medicare coverage of post-acute facilities.

"We want to avoid having patients who need to go to a nursing home but don't have a qualifying three-day stay because of a default to observation status," Clark adds.

Almost immediately, the hospital experienced an increase in teamwork and communication among staff, along with a huge positive response

from the medical and nursing staff, Clark says.

"We saw an increase in consistency in applying criteria and in using the inpatient only list, which we attribute to additional training. The integrated case management department gained increased visibility in the hospital by discussing the project with the various departments," he says.

*(For more information, contact **Teresa I. Gonzalvo**, RN, MPA, CPHQ, LNC, director of integrated care management, Good Samaritan Hospital, e-mail: tigonzalvo @shp-dayton.org.)* ■

Education was key to success of CM protocol

Research also critical

Before developing a protocol that delegates authority for determining patient status to case managers, a multidisciplinary team at Good Samaritan Hospital in Dayton, OH, spent several months researching the process, seeking advice from the Florida Quality Improvement Organization (QIO) and hospitals in Florida that had piloted a case management admission status protocol.

The hospital's integrated care management status team also worked closely with its QIO, Ohio KePro, and invited its representatives to participate at meetings and conference calls. The agency was involved in every step of the development, says **Teresa I. Gonzalvo**, RN, MPA, CPHQ, LNC, director of integrated care management.

"Like most hospitals, we have an ongoing challenge of determining whether patients should be admitted as inpatients or placed in observation status," she says.

The hospital's integrated care management department has partnered with a sister hospital, Miami Valley Hospital, on a project to establish the infrastructure for a case manager dedicated to observation patient reviews, tracking and trending charges and missed opportunities.

"The project showed overall improvement and modest gains. With Medicare's increased emphasis on medical necessity and the anticipated roll-out of the Recovery Audit Contractors, we knew we had to do more to ensure that every patient is placed in the proper status," she adds.

It has long been a challenge to get physicians to assign the proper status to patients, says **Donald P. Sickler**, MD, medical director for integrated case management.

"It is necessary to know the diagnosis and treatment to assign status but it's not necessary to know the status to diagnose and treat a patient; therefore, many physicians consider it a nuisance and put as little effort as possible into the process," he points out.

Before the project was implemented, patient status was, at best, educated guesswork by the physician, with the case manager working to get it correct during the hospital stay, says **Daniel L. Schoulties**, MD, vice president for medical affairs.

Many physicians were not familiar with InterQual criteria at the time, he adds.

Rather than training the medical staff on those criteria and expecting them to use them properly and objectively, it made more sense to allow case managers who use InterQual criteria daily to assign the patient status with support from the physicians, Sickler says.

The team began by educating the medical executive committee about admission status and the importance of getting it right.

"It is important that everybody involved with patient care knows how status is assigned and the ramifications of placing a patient in the wrong status," Sickler says.

The medical executive committee voted to have the patient status assignment delegated to the case managers. However, initially, some members of the executive committee were uncomfortable with having a case manager assign the status without a physician signature, Sickler says.

"Since the physicians had already signed an order on the chart delegating the responsibility for admission status determination to the case manager, we decided that it was redundant to ask them to sign off on the specific status assignment the second time," he says.

The team looked at the various parts of the admissions process, such as what forms were being used and which ones needed to be changed or what needed to be developed.

They modified the preassembled bed assignment forms and order set packages to be used in the emergency department for status determination.

The team created a case management status sheet that goes into the medical records. The sheet, which is signed by the case manager, includes the date and time the patient is placed in inpatient or observation status followed by check-off boxes for

the rationale for the status assignment.

For instance, there are boxes for the case manager to check off if the patient meets InterQual criteria; if a surgical procedure is on Medicare's inpatient-only list; if the patient failed outpatient treatment; if the patient has complications or comorbidities that complicates his or her care; or if the patient is at increased risk for a significant clinical event. There is a space for the case manager to add details, such as the name of the procedure or complication, when appropriate.

Under observation status, the case manager checks off if the patient meets the InterQual criteria for observation, if the patient does not trigger the inpatient criteria, or if Condition Code 44 is being used.

The team involved all areas of the hospital in the project including the post-anesthesia care unit, surgery scheduling, the referrals management center, direct admissions, the family birth center, the cardiac catheterization laboratory, mental health, insurance verification, patient access, and all patient units.

"For us, communication was the key in rolling out the process. Every department was affected by the change, so it was critical to bring in all the stakeholders and educate them," says **John W. Clark**, RN, BSN, manager, case management.

The team spoke at every nursing staff meeting at every unit in the hospital.

"We wanted all the key stakeholders from other departments to know what we were doing and the reason why," he says.

Before the project went live, the hospital made sure that all case managers were proficient with InterQual criteria. They instituted additional training on scenarios that can affect admission status, such as comorbidities or failure to improve with outpatient treatment.

"We practiced with difficult cases. Once we went live, we performed our own audits and requested an audit from Ohio KePro," Sickler says. ■

Multifaceted approach keeps patients flowing

The emergency department at Middle Tennessee Medical Center (MTMC) in Murfreesboro certainly qualifies as busy: It sees nearly 63,000 patients a year and averages more than 170 patients a day. Yet the average time it takes a patient to get to triage from entry into the ED is 14-17 minutes, and its door-to-doc time averages 35-40 minutes. The department leadership says its success is due to the ongoing pursuit of process improvement, often with several initiatives under way at the same time.

"It's a multifaceted approach," says **Kevin H. Beier**, MD, FAAEM, a physician in the ED. "We have a relatively small department for this volume."

Monty Gooch, RN, BSN, director of emergency services, says, "Our initiative to look at [patient flow] has been ongoing." Here are some of the more recent initiatives in the ED at MTMC:

- a lab phlebotomist hired specifically for the ED;
- the hiring of additional ED physicians;
- the expansion of point-of-care testing;
- the installation of a Lifenet Receiving Station.

This collaborative effort with the Rutherford County Emergency Medical Service enables the staff to receive wireless EKGs from the field.

The ED staff's response to the patient demand is extremely flexible, notes Beier. During heavy volume times, when they have 20-30 patients in triage, they use parallel assessment, he says. "We do the patient assessment right away in triage, order testing, and expedite their testing instead of them waiting three hours in triage to be seen," he says. Instead of having the nurse triage the patient up front, he says, the patient is brought back and triaged by a nurse and physician, which expedites testing orders.

They make extra efforts to pull patients into the back from triage, Beier says. "We do what we can to reduce the roadblocks to getting patients through the department."

Perhaps the initiative with the greatest immediate impact was the Lifenet station. "The county EMS initiated the program," says Gooch. "We had to buy the software program, plus a tabletop computer." (Minneapolis-based Medtronic is the vendor.) The LifeNet Receiving station was purchased through an $11,998 grant from the MTMC Foundation, a nonprofit corporation based in Murfreesboro (www.mtmc.org/index_waystogive.php).

"It has significantly improved MI care," adds Beier. "We can call the cath lab and cardiology at the same time, and sometimes we are able to have a cardiologist in the ED before the patient arrives." The hospital added an interventional cardiologist about six months ago, he notes. "Many of our patients that we would have transferred out, we now keep on site," Beier says. The cardiologist's office is directly across from the ED. ■

(Continued from page 6)

The care managers get a census report every day and begin by reviewing the newly admitted patients. They visit the patient, introduce themselves to the family, review the contact information and insurance information, and begin assessing the patient needs.

If the patient is in observation status, they give him or her a written notice of what will occur in the next 24 hours.

The assessment is documented in the electronic record and goes on to a summary screen, allowing all disciplines to see at it at a glance.

"Our goal is to make sure every patient really needs to be in the hospital and that they get the care they need when they need it so they can be discharged as soon as it is medically appropriate. Supplemental to that goal is protecting the financial resources for the hospital by adhering to state and federal regulations," she says.

The care managers work with the insurance companies, providing any clinical information they need. They continually evaluate the patient's progress and prepare for home services and medication that might be needed but is not affordable. They make daily rounds with the physicians, ensure that the patient receives tests and procedures in a timely manner, and monitor the patient's condition to ensure that it continues to meet InterQual medical necessity criteria.

Annual training sessions

The hospital holds annual training sessions for case managers with topics that include changes in coding, information on the MS-DRGs, complications and comorbidities (CCs) and major complications and comorbidities (MCCs), InterQual criteria, and other areas in which the case managers need to be informed.

"We know that insurance companies hire people with just a high school education and teach them what they need to know. Our social workers are very experienced and have a great education. We decided to include them in the education offered to registered nurses who are care managers," she says.

Initially, there were people who felt strongly that social workers could not function as care managers as effectively as registered nurses, Smith says.

"We believed that they could. That decision has worked out beautifully. Today, our social worker and RN care managers are so blended that you would not be able to tell which is which if you did not know them. The physicians are equally pleased with the services both provide. They both understand length of stay, DRG assignments, and continuity of care. They can all do all of the same things," she adds.

Express admission unit opened

The hospital recently opened an express admission unit that is used when the hospital census is high. If the emergency department physician makes the decision to admit the patient and he or she meets criteria, the patient may be placed in the express admission unit until a bed is available on the medical floor. Patients also may be placed in the unit if they are awaiting discharge to an extended care facility and the hospital needs a medical bed for patients following surgery.

"This has helped our patient flow a great deal," Smith says.

Patients in the express admission unit receive the same care they would get on the floor.

"The staff start the medication and facilitate the test the same way the staff would do it if the patient were in a permanent bed. We move the patient to a bed as soon as one is available," she says.

Each morning, the shift coordinators from each unit, the nursing supervisor, the admissions coordinator, and the care management staff meet to plan for patient flow needs and anticipate patient care issues.

"This single proactive step has decreased the stress of admission and discharge significantly," Smith says. ■

Final OPPS rule links quality of care to payment

Four new quality measures

In announcing its final rule for the Hospital Outpatient Prospective Payment System (OPPS) for calendar year 2009, the Centers for Medicare & Medicaid Services (CMS) reiterated its intention to strengthen the tie between quality of care furnished to people in hospital outpatient departments and the payments hospitals receive for those services.

The final rule, issued Oct. 30, 2008, adds four additional quality measures that hospitals must track, bringing the total to 11 quality measures on which hospitals must submit data.

CMS will reduce the 2009 payment update factor by 2% for most services for hospitals that did not report the required quality measures for outpatient services in calendar year 2008 and will also reduce the beneficiary cost sharing for those services.

"The direct impact of the new quality initiatives will be felt by the beneficiaries Medicare serves, and as the nation's largest payer for health care services, we are pointing the way to better, safer, and more efficient care for all patients," CMS acting administrator **Kerry Weems** says.

First time payment tied to quality

This is the first time that payment for outpatient services has been tied to quality reporting.

Hospitals already had been required to report on seven quality measures including five measures of standards of care in the emergency department for acute myocardial infarction patients transferred to other facilities for care and two outpatient surgical care improvement measures.

CMS is adding four more measures on imaging efficiency for the 2010 update and is considering adding up to 18 additional quality measures, ranging from screening for fall risk to management of community-acquired pneumonia, in future years.

The outpatient quality measures are part of CMS' value-based purchasing initiative, which links payment to quality rather than just the delivery of services. CMS is required by the Deficit Reduction Act of 2005 to have a plan for value-based purchasing in place by 2009.

"The need for case management in the outpatient setting becomes more apparent as CMS extends value-based purchasing to that setting. In many organizations, the role of the case manager has focused on cost efficiency of care for acute care patients. The role of the case manager in the outpatient setting should focus on cost-effectiveness, but more importantly on the quality of care with specific reference to the quality measures established by CMS," says **Deborah Hale**, CCS, president and CEO of Administrative Consultant Service LLC, a health care consulting firm.

In announcing the final OPPS rule, the agency reiterated its commitment to implementing the value-based purchasing initiative across the continuum of care and to become "a prudent purchaser of health care."

CMS also has announced that it intends to move toward not paying for medical care in the hospital outpatient department that harms patients or leads to complications that could have been prevented.

The policy corresponds to the policy that took effect in October of not paying for hospital-acquired conditions during the inpatient stay.

"In this final rule, we are continuing to pay appropriately for care while working with health care providers as we look for ways to make sure beneficiaries who come in for treatment of one complaint don't leave with two as a result of adverse events during their outpatient visits," Weems says.

CMS announced that it will continue dialogue with stakeholders to develop the health care-associated conditions policy including selection of conditions for which it will not pay and how the payments would be reduced for those conditions.

The final rule states that CMS will exercise its administrative authority under the Medicare statue to develop and implement a policy that would not pay hospitals for care related to illness or injury acquired by the patient during an outpatient encounter.

The agency will announce later the hospital outpatient health care-associated conditions policy, which will make adjustments to OPPS payment similar to the adjustments to payments for the hospital-acquired conditions in the inpatient setting.

Other changes in the final rule include:

- Creation of five imaging composite Ambulatory Payment Classifications (APCs), which bundle imaging services when two or more are provided in one session.
- Creation of four new APCs to pay for visits to Type B emergency departments, which are not open around the clock. The rates are generally higher for clinic visits to hospitals but lower than payment rates to hospital emergency departments that are open around the clock.
- Updating the conditions of coverage for ambulatory surgical centers, defining them as distinct entities that operate exclusively to provide surgical service for patients not requiring hospitalization. ■

Discharge Planning Quarterly

– the update for improving continuity of care

- Accelerated discharge
- Staff cooperation
- Placement strategies
- Reimbursement
- Legal issues
- Case management

Pre-admission prediction tool improves process

Idea is to gain patient buy-in

Sometimes the best response to regulatory and payer changes in health care is to improve the discharge planning process.

And sometimes the best way to improve the discharge planning process is to start discharge planning before the patient is admitted to the health care facility.

This essentially is what happened when a team of leaders looked at the industry changes occurring in orthopedic surgery discharges and post-surgery rehabilitation and realized that something major would need to be done.

A clinical performance management team at Massachusetts General Hospital in Boston closely examined orthopedic surgery costs, length of stay (LOS), process improvement, and Medicare regulatory changes, says **Pamela J. Tobichuk**, RN, ONC, a nurse case manager with the pre-admission orthopaedic total joint program. Tobichuk spoke about using a pre-admission prediction tool to improve the discharge process at the 18th annual conference of the Case Management Society of America.

"Most of our population wouldn't be able to go to an inpatient rehabilitation facility," she says. "The majority would need to go home or to skilled nursing facilities, which was a huge difference in what they were used to."

The regulatory and payer changes meant too many issues would need to be resolved: First, patients might have expectations that could not be met, and secondly, the hospital's LOS for these patients might increase as a result of fewer viable discharge options.

"We wanted to be proactive and see how we could maintain our good LOS, if not decrease it, and yet manage patients' expectations around what they'd be doing after surgery," Tobichuk says.

One member of the clinical performance management team came across a risk assessment tool that looked useful. It was described in a 2003 issue of the *Journal of Arthroplasty*, in an article, titled, "Predicting risk of extended inpatient rehabilitation after hip or knee arthroplasty."

"We took this tool back to the team and said,

CNE *questions*

1. Internal resources in a hospital tend to slow down once the hospital reaches what occupancy rate?

A. 90%
B. 85%
C. 95%
D. 75%

2. According to Brenda Keeling, RN, CPHQ, CPUR, what is the average cost of a patient day in the hospital?

A. $1,500
B. $1,000
C. $1,200
D. $2,000

3. What is the average caseload for care managers at Alamance Regional Medical Center?

A. 20-25
B. 25-30
C. 15-16
D. 21-23

4. In its final rule for the Outpatient Prospective Payment System, CMS added four new outpatient quality measures that hospitals must report, bringing the total to ___:

A. 11.
B. 18.
C. 27.
D. 32.

Answer key: 1. A; 2. C; 3. C; 4. A.

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

'How can we use this as a starting point for our program?'" Tobichuk says. "And that's where the development and implementation began."

After receiving permission to use the tool, the team adapted it for their own use, primarily by changing words to work better for an American population. The tool had been used in Australia, she notes.

The resulting six questions are scored with two- or three-point answers, meaning the patient is at the lowest risk, and one- or zero-point answers, meaning the patient is at the highest risk, Tobichuk says.

She calls patients prior to their surgery to ask them the tool's questions. As patients give answers, Tobichuk assesses their risk and discusses their post-discharge options, asking them, "Do you have a plan or preference for your discharge?" **(See how the pre-admission discharge planning process works, right.)**

Here are the tool's questions:

- What is your age?
- What is your gender?
- How far on average can you walk?
- What do you currently use to help you walk?
- Do you currently have any help from the community?
- Will someone be living with you who can care for you after your operation?

There is a maximum of 12 points. Anyone who scores greater than nine points is at the lowest risk for needing to be transitioned to a skilled nursing facility, Tobichuk says.

"If someone scores 10-12 points, then let's have that person go home," she adds.

At the other end of the spectrum, if a patient's score is fewer than six points, then that patient is at a high risk, she says.

"We would predict that patient would have to go to a skilled nursing facility for nursing rehabilitation," Tobichuk says.

Patients whose scores fall in the middle category of six to nine have moderate risk, and their discharge outcome is unpredictable, she adds.

"They either could go home with a visiting nurse or be transferred to a skilled nursing facility," Tobichuk explains. "If someone scores in the middle range and their preference is to go home, then that might be someone who could benefit from more physical therapy in the hospital to help them get over the hump, and we might send them home with more support."

When using the tool to assist with discharge planning, it's important to consider the patient's general motivation to work at rehabilitation in whichever setting the patient might prefer.

A patient who scores at low risk and who is highly motivated might not need home care services, but could go directly to outpatient physical therapy after being discharged from the hospital, Tobichuk says. ■

DP process begins five weeks before surgery

And ends after discharge

Discharge planning for orthopedic surgery patients at one major hospital begins well in advance of patients being admitted for surgery.

In fact, the discharge planning process begins about five weeks before the surgery, when the case management department sends patients a letter asking them to call a case manager for a 20-minute telephone interview, says **Pamela J. Tobichuk**, RN, ONC, a nurse case manager with the pre-admission orthopaedic total joint program at Massachusetts General Hospital in Boston.

"We have a list of upcoming surgeries through the scheduling operations," she says.

Tobichuk has found that it works better to ask patients to call them to schedule the initial telephone interview, rather than having case managers call them at home and catch them off guard or at a bad time, Tobichuk notes.

"I've tried calling patients to do the interview, and it didn't work," she adds.

With administrative support to pick up the voice mail messages from patients, Tobichuk has found the scheduled interviews to be an efficient use of her time.

"My hours are from 10 a.m. to 8:30 p.m., three nights a week," she says. "My hours are such that I can accommodate people, and I'm also talking to facilities and agencies throughout the day."

By scheduling the calls, patients and their families also benefit.

"I've found that patients will have their families over when I call, and they'll have me do a conference call to include the family in on the conversation," she adds.

This first telephone conversation is used to assess the patient's risk post-surgery and to work with the patient to come up with a plan for where the patient will be transitioned after surgery. They

use a six-question, pre-admission prediction tool.

Then Tobichuk will ask about the patient's needs and thoughts and then review the patient's answers to the assessment questions.

"In addition, we're adding questions about their living situation and the layout of their home," she adds. "Then we come up with their score, and we talk about it and what it means in relation to what they want."

The patient will agree to a plan, and if Tobichuk agrees with it, they'll proceed in that direction.

Occasionally, a patient will insist on a plan that Tobichuk believes will not work, so she'll agree to keep that as Plan A, but also will develop a Plan B as a backup.

Tobichuk tells such a patient: "We know you want to go home after surgery, and you scored seven points on the risk tool, so we'll try to get you home, but if your body doesn't cooperate with it, you need a backup plan," Tobichuk says.

Once those telephone conversations and pre-admission assessments take place, Tobichuk can decide whether a patient needs more education, and she can assess the patient's needs for pharmacy information.

"And I make follow-up calls to the payer or insurance company," Tobichuk says.

Also, if the patient will be discharged to a skilled nursing facility, she will call the SNF and ask it to save a bed for the patient.

"No one will guarantee holding it, but this is a nice population with a quick turnaround, and they'll only be in the hospital for a few days after surgery," Tobichuk says. "So we can almost hold a place for them in a facility." ■

Family interpreters can cause harm

They might purposely misinterpret

When hospitals rely on a patient's family members to interpret medical news, they might be placing the patient at risk, an expert says.

Family members sometimes purposely misinterpret information because of their own biases or agenda, says **Elizabeth Jacobs**, MD, MPP, an associate professor of medicine in the collaborative research unit at the Stroger Hospital of Cook County and Rush University Medical Center in Chicago. Jacobs recently studied the impact of having an enhanced interpretation service on Spanish-speaking patients' satisfaction and on hospital costs.

"When I ran the study, one of the things our interpreters did was introduce themselves to each Spanish-speaking patient, saying, 'My name is So-and-So. Here's my card, and you can keep it at the bedside and show to your doctor and family members,'" Jacobs says.

In one case, a family member told the interpreter, "No thank-you, we won't need your services," Jacobs recalls.

The interpreter told the family that the service was free, but the family still declined.

With a little investigation, the interpreter found that the family did not want the patient to know about her diagnosis, so the interpreter called Jacobs with this information.

"I told her I was glad she called me, and I called the attending and said, 'I want to make you aware of this situation,'" Jacobs says.

Jacobs advised the attending physician to be culturally sensitive but to give the patient the

CNE 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. ■

COMING IN FUTURE MONTHS

- Innovative ways to manage denials
- Managing the care of uninsured patients
- Ensuring that your patients get end-of-life care
- How a hospital recovered from a natural disaster

option of refusing the interpreter services and relying on family members.

"I told him, 'You can get an interpreter to go in there and ask what the patient would like, saying the family would like to be the ones to give you all of the information, or we could have an interpreter in here to talk with you directly about your health,'" Jacobs recalls.

The doctor handled the case as Jacobs' recommended, and the patient chose to have a medical interpreter present, Jacobs says.

"In 80% to 90% of cases, the patient does want the information from an interpreter," she adds. "And that's an example of what happens if you use an ad hoc interpreter."

Family members often will change the conversation or distort the doctor's words, often out of love or a misguided feeling that it's in the patient's best interest, Jacobs explains.

"So the doctor could be treating a patient with chemotherapy and not know that the patient doesn't even know her diagnosis," Jacobs adds. ■

2008 SALARY SURVEY RESULTS

HOSPITAL CASE MANAGEMENT™

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

Salaries are up, but case managers have more responsibilities

Creative strategies help with staff retention

Case management salaries are on the rise, but the vast majority of case managers are working far more than the typical 40-hour week, according to the 2008 *Hospital Case Management* salary survey.

The 2008 salary survey was mailed to readers of *Hospital Case Management* in the June issue. More than half of the respondents (65%) were case management directors. The rest were case managers, utilization managers, social workers, or had other titles.

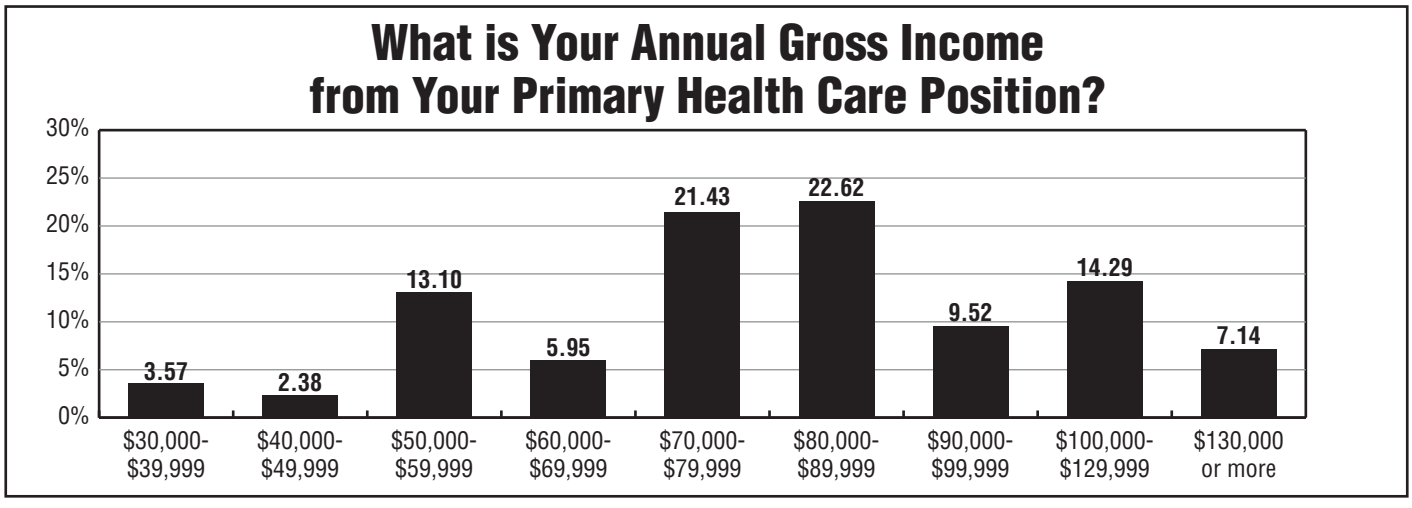
The majority of respondents (87%) to the *Hospital Case Management* 2008 salary survey report that they received a pay increase last year. The majority of raises (46%) were in the 1% to 3% range, with 34% reporting raises of 4% or more.

About 81% of respondents report receiving salaries of $60,000 a year or more, with the majority of respondents (55%) reporting an income in the $80,000-$90,000 range and 21% reporting salaries of $100,000 or more.

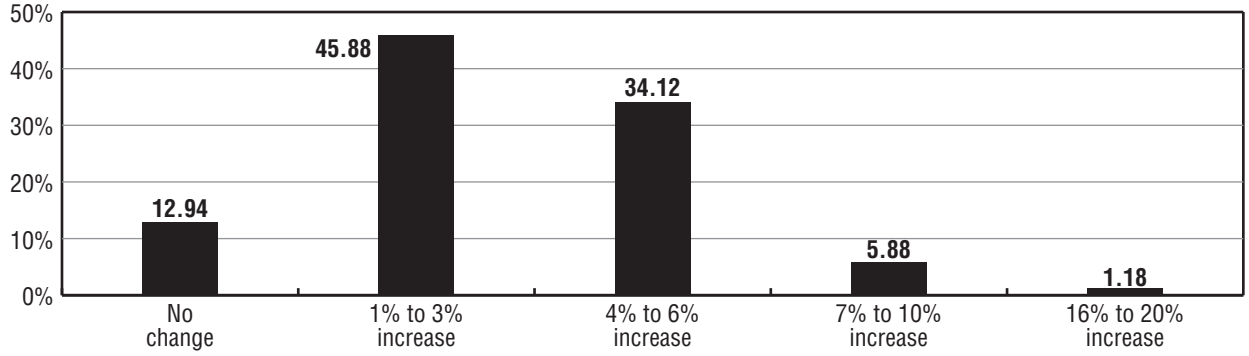
At the same time, case managers report putting in long hours. Nearly 87% of respondents report working more than 40 hours a week, with 36% putting in more than 50 hours.

CMs' duties expand

It's a general practice in many hospitals today to give tasks such as tracking core measures and clinical documentation improvement to the case managers "since they're already in the charts,"



In the Last Year, How Has Your Salary Changed?



says **Toni Cesta**, RN, PhD, FAAN, vice president, patient flow optimization for the North Shore-Long Island Jewish Health System and health care consultant and partner in Case Management Concepts LLC.

However, in many cases, the case managers already have more than they can handle and, since they are pressed for utilization review and discharge planning duties, other tasks may fall by the wayside.

In many hospitals, case manager staffing is not appropriate for the volume of work, Cesta points out.

Less direct patient care

The additional work that case managers must tackle decreases the time they spend with patients, creating an atmosphere of discontent that is causing some hospital-based case managers to look elsewhere for work, adds **Catherine M. Mullahy**, RN, BS, CRRN, CCM**,** president and founder of Mullahy & Associates, a case management training and consulting company.

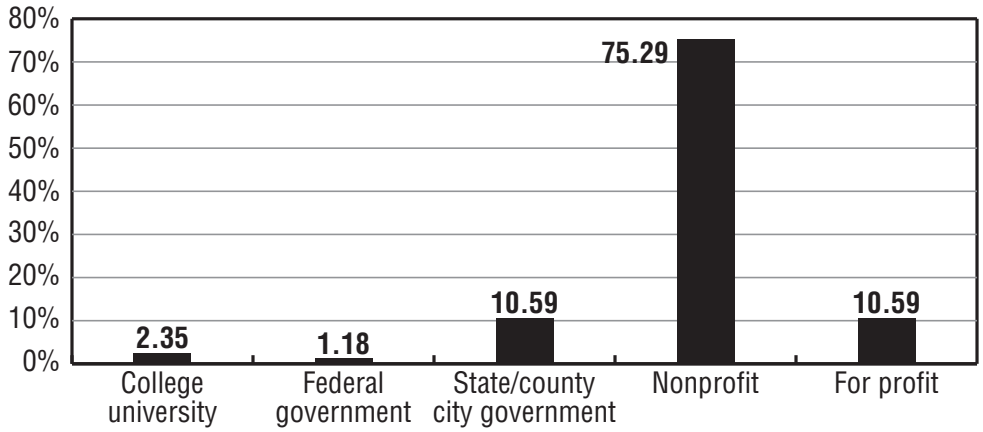
"Nurses go into nursing because they want to help people, not because they want to spend time doing paperwork. When hospital-based case managers have limited patient contact, they don't get that feel-good feeling and often get burned out and look for other opportunities," she says.

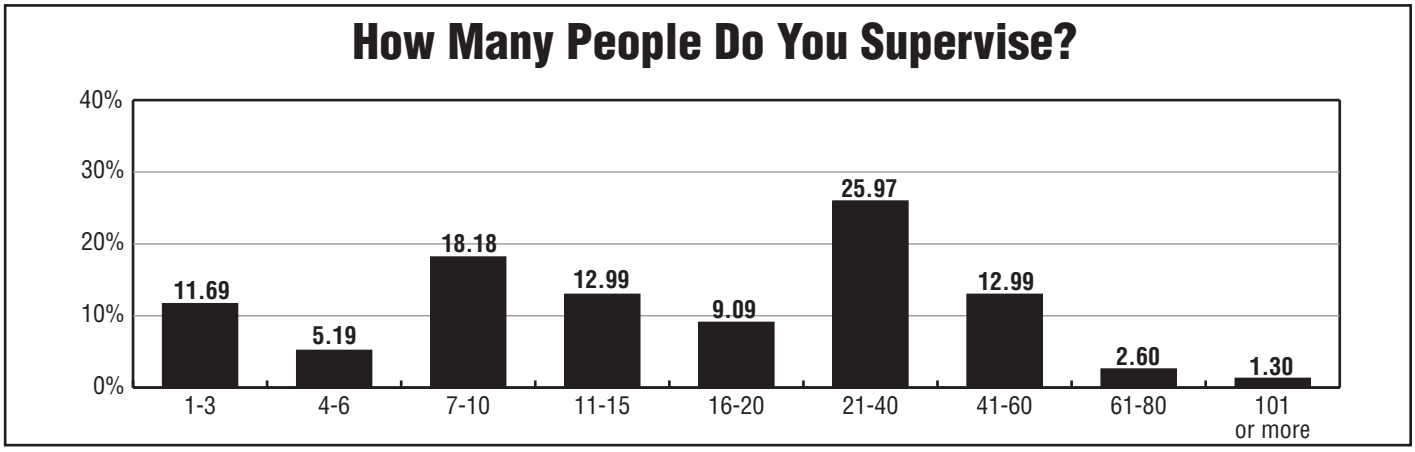
The nursing shortage and increasing demands placed on case managers have prompted case management directors to work with their hospital administration to find creative strategies to keep experienced staff on board.

While their hospitals struggle with the nursing shortage, case management directors have developed creative strategies to keep experienced staff on board.

For instance, Baptist Memorial Hospital-Memphis opened a resource center with nonlicensed staff who support the case managers,

Which Best Describes the Ownership or Control of Your Employer?





handling faxing, copying, and nonclinical calls to insurance companies and referral sources. Resource center staff also are responsible for tracking and delivering the Important Message from Medicare, notifying patients of their right to appeal their discharge.

Benefits for CMs

Since the center opened 18 months ago, following a restructuring of the case management department, turnover has been minimal, says **Darla Belt**, RN, director of performance review and accreditation.

The hospital also has limited the caseload of case managers to 20 patients, she says.

"During the reorganization, we combined the utilization review and case management functions. We expect a lot of the case managers so we try to take away things that don't require their expertise and give them a manageable load," Belt explains.

Baptist Memorial Hospital-Memphis pays for case managers to become certified and gives them a $500 bonus once they are certified. So far, 60% of the case managers have met the goal of having all case managers in the department certified by 2010.

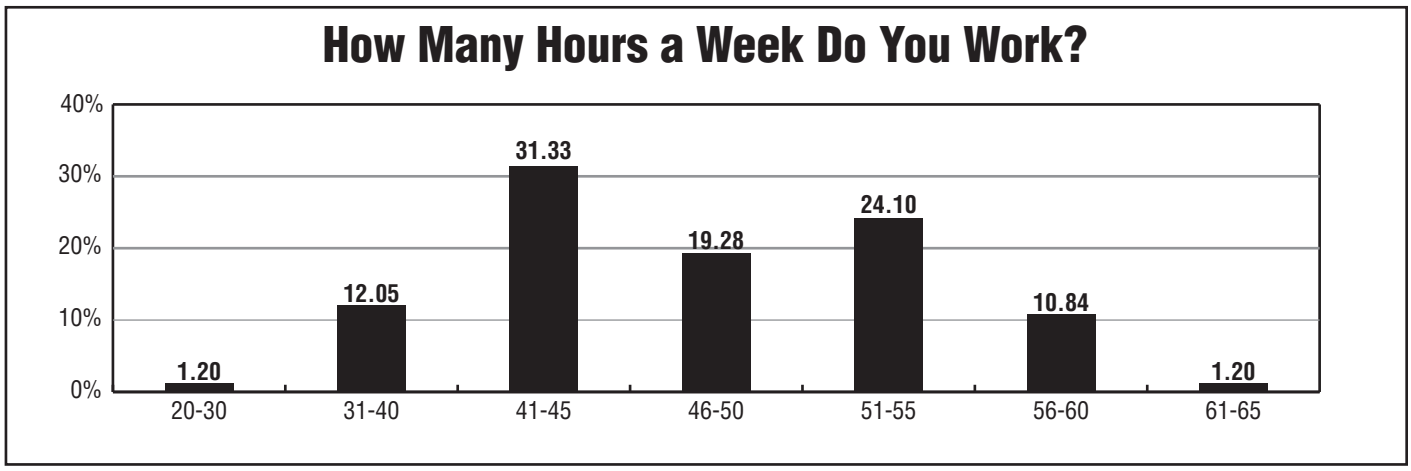
Harris Methodist Hospital in Fort Worth, TX, offers case managers flexibility in their starting and end times, allowing those with children to get them off to school and those who need to be home earlier in the day to come in earlier, says **Mari J. Finley**, RN, MBA, director of medical management.

The hospital administration is supportive of case management and has provided the department with a high-tech case management software system and laptop computers so the case managers can document while they are in the patient rooms, Finley says.

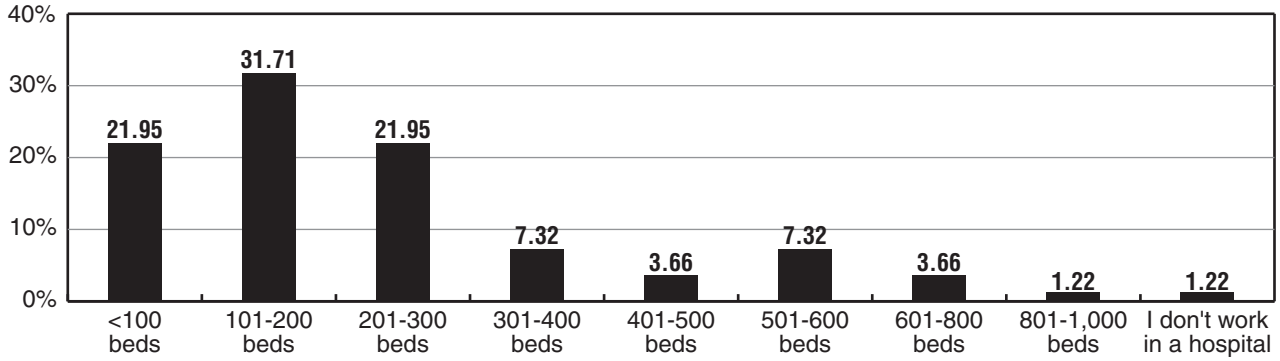
The department is undergoing a reorganization this year, with one of the goals being reducing the 30-patient caseload the unit-based case managers carry.

"We have been successful over the last few years in retaining our case management staff. It's always a challenge to find qualified case managers. Often, we have to take nurses who are new to case management and train them to perform the role," Finley says.

Recruiting qualified case managers is one of the biggest challenges that case management directors face today, and it's likely to get worse as today's case managers reach retirement age, Cesta adds.



If You Work in a Hospital, What is Its Size?



The aging of case managers poses a challenge for the industry, Cesta points out.

With hospitals offering higher salaries, shift differentials, and overtime pay to attract nurses during the nursing shortage, many younger nurses are opting to stay on the floor rather than go into case management because they can make more money, she says.

"The pool of cases managers is getting older without younger, experienced nurses coming along to take their place. This is going to be a bigger challenge than the nursing shortage in future years," she adds.

In fact, most respondents to the salary survey are older and experienced case managers. More than half (55%) have worked in case management for 10 years or longer.

About 57% of respondents are over age 50, while 14% report being 61 years or older. Only 9% report being age 40 or younger. ■