HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

AHC Media LLC

IN THIS ISSUE

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Get patient status correct up front to avoid financial repercussions

Inappropriate status hurts patients as well as the facility

As hospitals experience an increasing number of audits for medical necessity of admission, it's more important than ever to make sure that patients are in the appropriate status and that the medical record contains the documentation to support the status, says **Deborah Hale**, CCS, president and CEO of Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK.

Hale recommends taking a proactive and robust approach to ensuring that the patient status is correct.

"Hospitals are no longer in the position of being able to wait as long as 24 hours after admission to review patients for medical necessity. If hospitals are going to avoid improper payments, they have to look at medical necessity issues up front," she says.

According to the Centers for Medicare & Medicaid Services (CMS), 40% of overpayments ($391 million) found by the Recovery Audit Contractors (RAC) during the pilot project came from denials of medical necessity of admission, which means that the hospital had to pay back the entire DRG payment, Hale says.

Improper coding without complete documentation accounted for 35%, for a total of $331.8 million.

Delaying RAC implementation

CMS has delayed implementation of the RAC audits but still expects to reach its target of expanding the program to all 50 states by 2010. In addition, the agency is rolling out three other auditing initiatives that will examine hospital billing. These include: Medicare Administrative Contractors (MACs), Comprehensive Error Rate Testing (CERT), and Zoned Program Integrity Contractors (ZPICs). **(For details on the auditing programs, see *Hospital Case Management*, November 2008 and**

December 2008.)

"Hospitals need to take significant steps to avoid having significant recoupment as they experience an increasing number of audits for medical necessity of admission," Hale says.

The Medicare Benefits Policy Manual mandates that patient status must be determined by the physician and documented in the physician order, points out **G. Paul Stec**, MD, physician director of utilization and care management at Christus St. Vincent Regional Medical Center in Santa Fe, NM.

"At the same time, physicians are not trained in this area, nor does the selection of a status significantly impact the physician's treatment plan, billing, or payment. All hospitals face the challenge of documenting the proper status for the admission of patients, whether it's for an observation stay, an inpatient stay, or outpatient treatment," Stec says. **(For details on Christus St. Vincent Patient Intake Center's initiative to ensure that patient status is correct, see related article on p. 53.)**

Medicare doesn't say that case managers can't help a physician decide the status. In fact, CMS expects case managers to be involved in the decisions on patient status, Hale adds.

The RACs focused on one-day stays, but that doesn't mean that hospitals should substitute observation for one-day stays or medically inappropriate admissions, she says. Some short stays should be outpatient without the observation designation, she adds.

"Hospitals should spend the time and effort necessary to ensure that observation status is used appropriately. Don't let your goal be to eliminate all one-day stays. Let the goal be to eradicate medically unnecessary admissions," Hale says.

Can be dangerous not to use observation status

It's dangerous not to use observation status when it is appropriate, because it can raise a red flag for review if hospitals have a high rate of one-day stays, Hale points out.

"It also results in a lower case-mix index, affects the length-of-stay average, and the average cost of care," she adds.

Hospitals should be cautious about overusing observation status since the payment for observation status is not enough to compensate for the care of complex patients.

"If patients don't strictly meet inpatient screening criteria but their medical condition requires more than 24 hours of inpatient care, they may be appropriately admitted to observation and stay in observation status for days if the hospital does not have an effective process for physician advisor determination of inpatient admission necessity. This is not a good situation because of the low reimbursement associated with observation status," Hale says.

Inappropriate use of observation status when

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inpatient admission is appropriate can have a dire effect on the patient's responsibility for care since it may result in the loss of the three-day qualifying stay for skilled nursing coverage, she adds.

In addition, patients have to pay multiple copay amounts when they are in observation status. If they are in observation status for a long time and have a lot of diagnostic work-ups, it could result in a significant out-of-pocket expense, she points out.

"If you don't get patient status correct from the beginning, you can never entirely fix the problem. You can only manage it," Stec says.

For instance, a patient is placed in observation but is converted to inpatient status after two days in observation, then is discharged two days later. The patient has been receiving hospital services for a total of four days, but since the inpatient length of stay didn't begin until he or she was admitted as an inpatient, as far as Medicare is concerned, the length of stay is two days for a condition with a geometric mean length of stay of four days. If the patient receives post-hospital services, such as home health, inpatient rehabilitation, or inpatient psychiatric care, the hospital receives only the transfer DRG payment, Stec says.

Should skilled nursing care be required, the patient will not qualify as he or she does not have a three-day qualifying stay necessary for Medicare to pay for the skilled nursing facility.

In addition, Medicare's mandate that patients be fully informed of their financial responsibility gets more complicated when the patient status changes.

Using Condition Code 44

If a patient is admitted as an inpatient and the next day the case manager reviews the case and determines that the patient did not meet admission criteria, the case can be converted from inpatient to observation by using Condition Code 44, Stec points out.

"But then the patient has to be informed of his financial responsibility, which is likely to be higher. It's not a great public relations move to go to a patient's room and tell him you're going to charge him more for the same services for a reason he can't understand," he adds.

Changing the status using Condition Code 44 is complicated and time-consuming because Medicare requires that both the admitting physician and the utilization review physician have to agree on the status, Stec says.

Case managers should keep in mind that only a physician can make the judgment that a patient is not appropriate for admission, Hale says.

"The sicker a patient is, the easier it is to determine the admission status. It gets tricky when there is a question of whether the care can be delivered in the outpatient setting or if they need to be in the emergency department a little longer than usual," Stec says.

Admission screening criteria, such as InterQual and Milliman, are date that the nonphysician reviewer can use to approve the admission but it cannot be used to deny an admission, Hale says.

CMS states in the Medicare Benefit Policy Manual that physicians should consider a number of factors before deciding to admit a patient. Those include:

- the severity of signs and symptoms exhibited by the patient;
- the patient's medical history and current medical needs that influence the length of stay;
- the medical predictability of something adverse happening to the patient.

Physicians also should consider the types of facilities available to inpatients and outpatients, the hospital's by-laws and admission policies, and the appropriateness of treatment in each available setting.

This is where case managers can help ensure that the hospital is reimbursed for the admission by making certain that any safety factors that may play into that decision are documented in the record, Hale says.

"Physicians can't take social issues into account unless they affect patient safety. The medical record should have good documentation about the patient's living circumstances and why their care has to be managed in an inpatient and not an outpatient setting," Hale says.

Patients also may be admitted as an inpatient if they need diagnostic studies that are not readily available at the time and place the patients present and it would be unsafe to discharge patients and perform the test later as an outpatient, Hale points out.

Case managers should make sure that the documentation clearly supports the medical necessity for admission, Hale says.

For instance, if the patient lives alone with no available caregivers and treatment in the outpatient setting would jeopardize the patient's safety, make sure that information is included in the documentation.

Case managers also should make sure that the documentation reflects the failure of outpatient management and the relationship between the current and previous admissions.

Past medical history can have a big effect on medical necessity, Hale says.

For instance, a patient with chronic obstructive pulmonary disease (COPD) who presents with wheezing may need steroids and breathing treatment for less than 24 hours and is appropriate for observation or outpatient treatment.

A different patient with the same symptoms who has end-stage COPD and has been on mechanical ventilation recently may be appropriate for an inpatient admission.

Documentation should reflect the difference, Hale says.

"Patients who are admitted to observation should have signs and symptoms that indicate the need for diagnostic testing and a treatment plan," she says.

Many hospitals that are dealing with throughput issues may use a four-hour benchmark when a patient can be treated in the emergency department and when he or she needs to be moved to observation.

"When the hospital staff evaluate patients who are potential for observation, they should determine if the patient needs at least eight additional hours of care once their emergency department care has been completed," Hale suggests.

It is important to have a formal admission order that specifies if a patient is admitted as an inpatient or placed in observation status, she says.

The physician's order for observation status must be written, dated, and timed before the hours for observation service can be counted, Hale says.

"The order for inpatient care must be stated as such, dated and timed by the physician. The time and date of an inpatient admission cannot be backdated," Hale says.

Physicians must have a reasonable expectation that a patient who is placed in observation will require more than 24 hours of care in order to issue the order for inpatient admission, Hale says.

"Even if the patient doesn't stay 24 hours, inpatient admission is appropriate if that's what the physician believed when he or she made the decision," she says.

*(For more information, contact **Deborah Hale**, President and CEO, Administrative Consultant Services LLC, e-mail: dhale@acsteam.net.)* ■

What's appropriate for observation?

Here are some tips for determining the correct status

According to the Centers for Medicare & Medicaid Services (CMS), observation services are "a well-defined set of specific clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment."

The purpose of observation is to determine the need for further treatment or inpatient admission, according to the Medicare Benefit Policy Manual.

"Patients who are appropriate for observation have medical issues that need further evaluation but at the time, the physician does not have enough information to make a decision to admit the patient or discharge him from the hospital," says **Deborah Hale**, CCS, president and CEO of Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK.

CMS states that the majority of patients who are admitted to observation present through the emergency department but need a significant period of assessment, reassessment and/or treatment, Hale points out

"Observation is not just for determining whether a patient should be admitted, but it's also for patients who have significant signs and symptoms that need treatment but should not take more than 24 hours," she adds.

During the observation time, if it is determined that the patient needs further treatment, he or she can always be converted to an inpatient admission, Hale says.

CMS says covered observation services can be completed in 24 hours or less in the majority of cases.

"CMS does not limit observation to 48 hours, but in order to be efficient and effective, hospitals need to have processes moving efficiently enough to have information needed to make a decision quickly," Hale explains.

Docs: Don't rely on observation

Hospitals shouldn't allow physicians to make observation a routine stop between the emergency department and an inpatient admission, Hale warns.

"If the emergency department physicians have trouble determining the level of care, they

Common Observation Billing Errors

- Observation billed for routine postoperative care;
- Incorrect counting of observation hours;
- Condition Code 44 not reported when appropriate;
- Drug administration times not documented and injections/infusions not billed;
- Self-administered drugs integral to treatment are billed as noncovered;
- Bedside procedures not billed. These include AccuChecks, Foley catheter, guaiac tests, etc.

Source: Administrative Consultant Services, Shawnee, OK.

sometimes admit everybody to observation and let the attending sort it out. This is inappropriate and may result in financial penalties for the patient," she adds.

Observation is not appropriate for patients who are waiting for a nursing home, she points out. It's also not intended for patients who need certain outpatient services that the hospital doesn't provide, such as patients who missed their dialysis appointment and show up in the emergency department, Hale says.

"Hospitals are facing the problem of finding a placement for patients who come to the emergency department and don't require an acute level of care. They can't admit them, but they can't discharge them safely, either. It's a big challenge," she adds.

Services should not be billed as observation services if they are part of other services covered under Medicare Part B, such as outpatient surgical services, Hale says.

The Ambulatory Payment Classification (APC) payment for outpatient surgical procedures includes operating time, supplies, medication, anesthesia, antibiotics, and a routine recovery period of four to six hours but can be up to 24 hours, Hale points out. This means that time in the recovery room can't be billed as observation, she adds.

CMS will not pay for observation services when there are general standing orders for observation status after outpatient surgery, Hale says.

"Medicare is saying that there is a clear difference between inpatient and outpatient surgery and that observation status after outpatient surgical procedures is appropriate only when there are complications and the recovery time is not routine. Since complications cannot be predicted, hospitals should not have standing orders for observation," she says.

In addition, observation services should not be billed when they occur concurrently with diagnostic or therapeutic services that include active monitoring, she adds.

For instance, a patient comes in with an episode of gastrointestinal bleeding and is placed in observation. The physician orders a colonoscopy that is reimbursed by APC payment from Medicare. The time that the patient is in the colonoscopy lab cannot be counted in the observation time.

The same is true for a patient who is in observation with chest pain and receives a heart catheterization, Hale adds. The hours that the patient is in the catheterization lab cannot be counted as observation because those services are paid for by an APC payment.

Hale urges hospitals not to go too far in carving out minutes for extra services. For instance, if a nurse comes in to insert a catheter while the patient is in observation, it isn't necessary to carve out 15 minutes for that procedure. ■

Status determined before bed assignment

UR nurses, physicians work together to get it correct

Before a patient at Christus St. Vincent Regional Medical Center is registered or assigned to a room, a utilization review nurse in the hospital's Patient Intake Center reviews the patient's clinical information and collaborate with the admitting physician to determine that patient's status.

Getting the patient status correct on the front end ensures compliance with the Centers for Medicare & Medicaid Services (CMS) regulations, assures that the hospital is paid appropriately for the services it provides, and will help the hospital avoid problems when the Recovery Audit Contractors (RAC) and other CMS auditors review hospital records, says **G. Paul Stec**, MD, physician director of utilization and care management at the Santa Fe, NM, community hospital.

"We establish the patient's status prior to registration and prior to the room being assigned. This way, we aren't changing a physician's order. We are just making sure that the order that is being issued is correct. Once you get the status registered wrong, you can't fully correct the mistake," Stec says.

The goal of the Patient Intake Center is to make certain that the admissions status is correct and that the documentation is complete so that when an audit does occur, the documentation is so solid that there is no question about it, he adds.

"It is a red flag to CMS if there is not a clear patient admission order. If the order says only 'admit,' the RAC is going to dig deeper into the chart. We want a clean order that avoids audits," Stec says.

Every admission goes through center

Every admission to the acute care hospital, regardless of payer, goes through the hospital's Patient Intake Center, with the exception of patients on the labor and delivery floor.

The Patient Intake Center nurse screens the admissions whether they are direct admissions from physician offices, transfers from other hospitals, admissions from the recovery room after surgery, or admissions from the emergency department.

Physicians either call the Patient Intake Center and give the nurse a verbal order or use a preprinted faxable form. The nurse reviews the patient's clinical information and the admission orders and makes sure that they correlate.

"Part of our process is the exchange of clinical information. The nurse is making certain that the status fits the patient and that it is properly documented in the admission orders. When the physician faxes or verbally issues the admission order, the clinical diagnosis should coordinate with the order. If the orders and clinical information do not correlate, it is the nurse's obligation to call the doctor and get the information needed," Stec says.

If the patient status clearly should be observation, the nurse contacts the physician and discusses it.

"Since she is a RN, if they agree that the order should be different, she can take the verbal order and make the status more correct, as per the physician's order," Stec says.

When a patient is being transferred from another hospital, the patient intake nurse makes sure that the patient has an accepting physician who will care for the patient at St. Vincent. "This ensures that the physician who is caring for the patient in the hospital is fully informed about the patient's clinical condition," he explains.

At St. Vincent, the emergency department physicians do not handle admissions. They call the admitting physician who may be either a physician in the community or a hospitalist.

The hospital's hospitalist program provides care for about 70% of the patients.

The Patient Intake Center nurse fills out an admissions work sheet and sends copies to bed control and the admitting and registration department.

The worksheet includes patient demographics, diagnoses, comorbidities, primary admitting diagnosis, and primary comorbidity. It includes information that the admitting nurse can use for room selection, such as fall risk, mental status, and need for isolation, along with information about the level of care.

Another section includes the time the nurse got the order, the time the work sheets are faxed, and the time she contacted the physician for additional information if appropriate.

There is a section the nurse can use if she needs to ask the physician for additional clinical information.

If the patient is being transferred from another hospital, there is a section with the name and phone number of the transferring physician and the name of the accepting physician.

The bed control department uses the information to select the level of care and identify the proper bed for the patient.

The registration and admitting department verifies the insurance, notifies the insurer, and admits the patient.

"What the registration staff must complete for an observation patient is different from what they must do for someone admitted in inpatient status. Our process ensures that they have the information they need to complete the registration," he says.

At St. Vincent, the Patient Intake Center is staffed by nurse case managers 16 hours a day. During the night shift, the patient intake process is completed by the nursing supervisor who also is in charge of bed control. Her work is reviewed by the Patient Intake Center nurse the following morning.

The hospital has an observation management case manager who is assigned to review all patients in observation status within an eight- to 12-hour window after admission.

"If she finds anything that might have impacted the patient status, she discusses it with the PIC nurse," Stec says.

"We have an active auditing program and a continuing education process to ensure that we are

(Continued on page 59)

CRITICAL PATH NETWORK™

Six Sigma project improves documentation of patient status

Initiative includes standardized admission process, better communication

A Six Sigma project to improve documentation of patient status has resulted in increased satisfaction, increased productivity, and decreased denials for Medicare reimbursement for Virtua Health, a four-hospital health system in southern New Jersey.

"We needed to avoid being denied for services and to meet Centers for Medicare & Medicaid Services [CMS] compliance requirements. At the same time, we wanted to improve our ability to notify the patient of his or her admission status at the time of service," says **Adrienne Elberfeld**, Six Sigma Black Belt and Six Sigma champion-operations improvement.

The initiative has resulted in a dramatic decrease in the number of cases for which the hospital couldn't bill because the patients didn't meet medical necessity criteria, adds **Rita S. Veterano**, RN, BS, MSHA, assistant vice president, corporate case management.

"Patients are admitted through the emergency department and are assessed by the emergency department physician who initiates the process about what level of service is required — whether the patient is treated and discharged, admitted as an inpatient, or admitted to observation. One of our main concerns when we started this project was that many times, the patient status wasn't reflected in the medical record," she says.

The hospital system's Six Sigma team included representatives from nursing, case management, finance, compliance, information technology, patient access, and physicians.

At the beginning of the project, the team examined how the information was shared once the emergency department physician or admitting physician made the decision on patient status.

At that time, physicians wrote an order that was transferred to the emergency department unit secretary, who called the bed flow coordinator, who contacted the unit to alert the staff that a patient was being admitted. Many times, the bed flow coordinator didn't tell the nurse on the floor the correct patient status and many times, nobody wrote the status down, Veterano says.

"With the manual system, it was a labor-intensive process. We were counting on people instead of entering the information in the electronic medical record," Elberfeld says.

At three of four Virtua campuses, the patients were being held in the emergency department for as long as six hours after their admissions status had been determined and a bed had been assigned.

"The patient was registered in an inpatient bed but didn't leave the emergency department. Paperwork said they were on the unit, but physically, they were still in the emergency department. This caused problems on many levels. For instance, there could be a change of status while the patient was in the emergency department and this might not be communicated to the unit," Veterano says.

The team created standardized processes at all four hospitals, including standardized physician order paperwork and computerized physician order entry that has the patient status line highlighted in the emergency department physician order entry.

The team educated the medical staff on inpatient vs. observation criteria and the new standardized practices and presents monthly education through the medical management committee. A presentation on observation status is included in the new

physician orientation program.

At Virtua, case managers review 100% of patients using InterQual criteria, even the short-stay patients who have been discharged from the hospital.

If a patient doesn't meet criteria for medical necessity, the case managers discuss the case with the attending physician as well as the medical director dedicated to the case management department.

"If the medical director doesn't agree with the clinical decision, he reaches out to the attending physician as well as the emergency department physician who initiated the patient status," says Veterano.

The case management department creates reports on observation action and its financial impact on a weekly basis for the health system's senior leadership group.

The department tracks admission status trends and uses the information to target trends, which physicians may need additional education on from the medical director for case management.

For instance, if data show that a particular physician tends to place patients in observation status when they should be admitted as inpatients, the medical director for case management educates the physician, Veterano says.

"At Virtua, the patient is our primary focus. When we began our initiative to ensure that patients were in the correct status, we also worked on improving our communications to make the patient aware of their admission status and what it means," Veterano says.

For instance, observation is considered to be an outpatient service, and there may be a Medicare copay associated with the stay, she notes.

"Patients sometimes didn't understand that even though they stayed overnight in a hospital bed, they still were considered an outpatient and had a Medicare copay. We needed to provide education to patients and family members in order to meet that challenge," Veterano adds.

In additional to helping patients understand their admission status while they are in the hospital, the case management department takes a proactive approach to the problem and educates seniors in community settings.

"We educate them while they are here, but we decided to go into the community and speak to community groups to educate our seniors about what observation status means before they go to the hospital," Veterano says. ■

ED slashes average wait time by more than an hour

Team studies facilities, creates own model

No ED cuts its average door-to-doc time from 93 minutes to 20 minutes by accident. The success story at Memorial Hermann Memorial City Medical Center in Houston was the result of discovering a patient flow model at another facility that was superior to theirs, and then continuing to search out additional models to come up with their own system that best addressed their specific needs. The result was a model they call ExcelERate, which includes a more detailed nurse assessment up front, parallel processes, and the carving out of an intake area within the ED.

"We reoriented our entire space, putting divider screens in four rooms to duplicate our capacity," explains **Michele Bell**, RN, MBA, chief nursing officer at Memorial Hermann. The department now has 10 intake and procedure rooms; five continuing care rooms with stretchers; four rooms with two recliners each, separated by curtains, with 13 spaces for continuing care and 13 acute care beds; and an overflow room that has 10 chairs.

The changeover began when **Jim Parisi**, RN, Memorial Hermann Healthcare System executive of emergency services, went to Phoenix to visit Banner Estralia Hospital at the invitation of its client, Cerner. Banner Estralia was using Cerner IT systems and had gone paperless. "We took a tour of the hospital that in started in the ED — and we just stayed there," he recalls.

What impressed Parisi was that the busy ED (60,000-70,000 visits a year) "seemed so well organized and relatively quiet." He started asking lots of questions and, when he came home, he met with TeamHealth, which provides ED coverage for the system. "We agreed that while this would not do everything for us, their 'split-flow' process had the most chance of anything we had seen to help us," he says.

Then, a team that included physicians, nurses, and representatives from the lab, radiology, and administration visited the Banner facility. "As an interdisciplinary team, they had to envision how this would work in our physical plant," says Parisi.

The research didn't end there, says Bell, who joined the team on the Phoenix trip. "We also saw several children's hospitals in Cleveland, because

we will be putting in a children's ED in June, and then we kind of combined the best of all the models," she notes.

Because the staff already had had extensive experience with Six Sigma methodology, the conversion process also was facilitated by Black Belts and Green Belts, "so we knew we could show measurable improvement," says Bell.

That they have accomplished: Parisi says the left-without-treatment rate had been as high as 9%-10%, "and now it is way less than 2%." That improvement, adds Bell, also is reflected in the department's Press Ganey patient satisfaction scores. "We started in very low digits and now run anywhere from 80 to 95," she reports.

When the ED at Memorial Hermann Memorial City Medical Center in Houston was preparing to implement its new flow model, ExcelERate, it was clear that the revised ED processes could not be run by just anyone, says **Michele Bell**, RN, MBA, chief nursing officer at Memorial.

"The ED brought in six coordinators — RNs — who are on 24/7," she says. "They are the best nurses." These individuals, she notes, are responsible for keeping the rest of the staff and the lab moving. They are constantly running to the front and checking the waiting room as well, because, Bell says, "I want it empty all the time."

Speed is the toughest part of the model, she says. "The staff voted on their strongest leaders who they thought could do this model," Bell says. The entire ED staff are evaluated on three metrics: turnaround time, door-to-doc time, and customer satisfaction. "They can earn up to an additional 2% of their salary," she says.

Not every staff member was thrilled with this new approach, Bell concedes. "We lost a lot of them and replaced them," she says. "There are some people you just know are not going to change."

For some staff, however, it was just a case of needing to see the model in operation. "The nursing director for the ED was dead set against it at the beginning," recalls Bell. "It's very hard for an ED nurse to focus on treating people quickly."

However, she says, that nurse manager now is "very proud of our performance." ■

ED's turnaround time cut by almost 30 minutes

Process 'pulls' patients out of waiting area

By implementing a Lean process change that it calls TAPP (Team Assessment Pull Process), the ED leadership in the Children's Healthcare of Atlanta system has realized a 25-minute reduction in median overall turnaround time, from 192 minutes to 167 minutes, excluding its fast track. The ED also achieved a 16-minute median improvement in door-to-provider time, from 44 minutes to 28 minutes, at its Scottish Rite campus. In addition, median length of stay has dropped from 136.5 minutes to 122 minutes.

TAPP works like this: The patients are greeted in the waiting room by a patient access greeter. A registered nurse is sitting next to the greeter from 9 a.m. to 3 a.m. They are then assigned an acuity level by the triage nurse. "From there, they show up on our [ED automation software program] board as a patient in the waiting room," explains **Cresta Pollard**, RN, BSN, assistant nurse manager. "Then, when a doctor is ready for a patient, they put their name as well as their communication number on the board."

The nurse will do the same, she explains. Once a second team member has signed up, they will call the first via the facility's internal phone system (ASCOM) and say he or she is ready for the patient. The nurse or a tech then will get the patient and tell the doctor what room they are going to. The doctor will meet the nurse in the room, where they will obtain a history, conduct a physical exam, and communicate the plan of care. The nurse will carry out the orders.

Before this change, the work in the ED had been "scattered and frantic," says Pollard. "We would have three to four patients at a time and put them into rooms, but they could be waiting an hour or more for a doctor; you might have orders on all four working at the same time, start with one patient, then go to another, and by the time you got to the last one, it could be an hour before it was all done."

Jennifer Berdis, RN, BSN, manager of clinical operations, says, "The nurses actually had to make decisions about what patient was a priority, while every doctor felt their patient was a priority, so the nurse was stuck in the middle. Now they do not have to make that decision because they are only working with one patient until they are done with orders."

The "pull process" refers to the fact that each patient is pulled by the nurse into the pod, or treatment area, where they meet their team. There are three pods in the department (including fast track),

each with 17 rooms. The number of pods that are open and the number of team members varies according to the census. At full census (3 p.m.), there are approximately six nurses and three physicians per pod.

James Beiter, MD, the medical director, says, "The intention was to have the physicians stay within a team and a pod, but because we will open and close certain areas in the ED, it's hard to keep us in one area; we go where help is needed. It has not been as strict as it has with the nurses." ■

Break down these barriers to medication safety

Take an in-depth look at your own ED

A patient's chart is unavailable. Verbal orders are not yet written in the patient's chart. The identification bracelet is not yet on your patient. These are three reasons that an ED nurse may fail to comply with one of The Joint Commission's National Patient Safety Goals (NPSGs): the requirement for use of at least two patient identifiers.

A new survey of 2,200 ED nurses representing 131 EDs reveals that these and other barriers to compliance with the medication-related NPSGs are quite common.[1]

Leaders of the Emergency Nurses Association (ENA) chose to study this topic because emergency nurses identified compliance with the medication-related goals as a "particular challenge," according to **Denise King**, RN, MSN, CEN, immediate past president. King says to her knowledge, no other study has examined the NPSGs in this way.

"Emergency nurses should utilize the findings to take an in-depth look at their own ED" to identify barriers to compliance and develop an action plan, she says.

The ED at the University of Kentucky Medical Center in Lexington, like many others, has found compliance with the patient identification and universal protocol goals a particular challenge, says **Mary Rose Bauer**, RN, MSN, one of the study's authors and quality improvement coordinator for emergency/trauma services at the center. "Both of these were shown to have multiple barriers to implementation in this study," she says.

Bauer says the following practice changes were made in her ED to remove barriers to compliance:

- **Additional education on the medication-related goals is given to ED nurses during staff meetings and competency days.** "A monitoring program has been initiated that looks at compliance and provides feedback to the staff," says Bauer.
- **As part of "Patient Safety Days," ED managers take two weeks to retrain staff on one of the medication-related goals.** "This effort is designed to get all staff the same current information and incorporate it into their practice," says Bauer.

At the University of California — San Diego Medical Center ED, the most challenging NPSG was medication reconciliation, says **Tia Moore**, RN, CEN, clinical nurse educator of the ED. *(Editor's note: This goal is being evaluated by The Joint Commission and will not affect surveys in 2009.)* "As we have many 'frequent fliers' that present with their large bags of medications, it became increasingly time-consuming to have to re-document all of their medications with each visit," she says. "A simple five-minute triage could turn into a 30-minute ordeal if the patient had a large amount of medications."

To help speed the process of initial triage, nurses rewrote the triage page within the computerized charting system. Now, the patient's medications transfer with their chart for every ED visit. Now all nurses have to do is verify during the initial triage that the patient still takes the same medications, including the dosing and frequency. Then, any additional medications are added, and those no longer taken are deleted.

The new process takes more time for initial entry of the medications if the patient has not been seen in the ED previously, acknowledges Moore. "While it does indeed take more time to do this, we are making sure that any potential medication-related interactions or allergy concerns are documented from the beginning," says Moore. "Once the initial input is made, the speed of reviewing for dose accuracy is significantly improved should the patient again present to the ED."

Likewise, the patient's discharge paperwork interfaces with the triage medication page and automatically prints the name of each medication, rationale for use, proper timing, and any potential side effects. This paperwork gives nurses another chance to review the information with patients before they leave the ED.

Reference

1. Altair J, Gacki-Smith J, Bauer M. Barriers to emergency departments' adherence to four medication safety-related Joint Commission National Patient Safety Goals. *Jt Comm J Qual Pat Safety* 2009; 35:49-59. ■

(Continued from page 54)

getting the status correct. The staff get together once a week and review the cases about which there are questions," he adds.

The hospital set up its Patient Intake Center in December 2008. The need became apparent when the hospital became affiliated with Christus Health, a nonprofit, faith-based system of more than 40 hospitals and long-term care centers with headquarters in Dallas, Stec says.

"The case management director and I visited Christus Santa Rosa Hospital in San Antonio, TX, which the Christus system had designated as a Best Practice Patient Intake Center. We worked with Santa Rosa's case management director Roxanne Jenkins to adapt the model to meet the needs of St. Vincent," he says. ■

RNs, LCSWs cross-trained to work as case managers

One person is go-to for patient, family, insurer

When Brookhaven Memorial Hospital Medical Center redesigned its case management function, merging the social work, utilization review, and clinical guidelines departments, the hospital cross-trained staff in all three departments to handle case management functions.

"We wanted to improve service to patients by having just one person — a case manager — go to the bedside and coordinate their care and communicate with the rest of the health care team and the managed care companies," says **Ellen Salvo**, LCSW, director of case management and utilization for the community hospital, located in the town of Patchogue in Long Island, NY.

The model is effective because there is one person for the doctor, the family, and the patient to contact for information; no one has to track down several people to get a picture of the patient, Salvo says.

"When a managed care provider needs to know about a patient, there is one person to talk to who knows the treatment plan, how the patient is progressing, whether he still meets criteria, and what the plan is for discharge," she says.

Before the reorganization, social workers had handled discharge planning and worked with patients with high-risk social issues. The utilization nurse handled utilization review. In addition, the quality management department was responsible for quality issues.

When the departments were combined, staff working in all three positions were cross-trained to handle all of the tasks of both disciplines.

"There were three different people looking at the chart and reviewing the information. This was not as efficient as it could be," Salvo says.

When the departments were combined, staff who had been working in all three positions were cross-trained and began working in teams of two. The skill sets that each person brought to the team made it possible for one person to handle all the functions required, Salvo adds.

In order to make it work, the hospital created case management positions, which were filled by the social workers and the nurses from the utilization management department and the quality management department.

"They each are called 'case manager' and they work together as a unique and powerful team. They can bring all their skills to bear in resolving any issue and performing any function that it once took more people to accomplish," Salvo says.

The case managers have specific geographic assignments in the hospital and are responsible for coordinating the care of patients who come into those beds. Each case manager is assigned to about 15 beds and is responsible for the main functions of utilization review and discharge planning for those patients.

"The actual caseload can vary due to patients being discharged and new patients being admitted," Salvo says.

Although team members have total responsibility for their own caseload of patients, they collaborate closely with their team and other disciplines when appropriate to coordinate care for the patients.

"If it is a clinically complex issue, the case manager with a social worker background draws upon the other team member as a consultant and vice versa. If a case manager with a nursing background has a case with a lot of social issues, their teammate with a social worker background would be the consultant," she says.

The multidisciplinary model extends to the management team, which includes a supervisor who is a social worker and a manager who is a nurse with a strong utilization background. Salvo, the director, is a social worker.

"We are a team and we rely on each other's skills and education. Everybody has learned to appreciate the work of their counterparts. If people are

accustomed to doing one particular job, they tend to be focused on their responsibility and work independently of other people. In this model, people with different sets of skills and education work together and learn from each other," she says.

The two disciplines rely on each other for help in challenging situations and work together as a cohesive team, Salvo says.

"Many times, people are not able to determine who is the nurse and who is the social worker on a team. There is a lot of cross-training and learning," she says.

The case managers are part of the multidisciplinary team and participate in daily patient rounds, along with the medical director for case management, the nurse manager, and the nurses on the unit to review each patient.

The case managers are supported by the department's placement office, which handles placement for short-term and long-term post-acute services and by case assistants who work on each floor, to assist in carrying out the discharge plan developed by the case manager.

The case managers meet with the patients and family to discuss discharge planning and communicate the plan with the health care team and the physicians.

They notify the placement office to locate beds for patients who need short-term or long-term post-acute care.

The placement coordinator identifies available beds in facilities and seeks authorization for payment from the patient's insurance. If it's a short-term placement, they pass the information on to the care managers who discuss the choices with the family.

If it's a long-term placement, the patient and family meet with the placement coordinator to talk about the placement process.

One case assistant is assigned to each floor and works with four case managers. Part of their function is to handle nonclinical duties such as faxing, copying, and other details that help get the work done.

The case managers and case assistants have laptops and zone phones, which are tied to the hospital switchboard.

"They can do a lot of their work right in the patient room on the laptop. It makes it much more efficient," Salvo says.

A team of case managers and a case assistant works from 8 a.m. to 4 p.m. on Saturdays and Sundays.

The hospital typically has a case assistant and two or three case managers covering the emergency department and the entire hospital on weekends. The number of staff depends on anticipated volume.

The weekend staff are a combination of full-time case managers and per-diem case managers. The full-time staff rotate on the weekends and take compensatory time off during the week.

"We try to limit the full-time staff on weekends because it leaves us short during the week," Salvo says.

As part of its initiative to improve patient throughput, Brookhaven Memorial Hospital Medical Center has hired facilitators who work with the high-volume physicians on issues when they aren't in the building.

"They can write prescription orders and complete the discharge summaries so it doesn't delay the discharge," Salvo says.

In addition, the case management department is working with nursing homes and other agencies that provide post-acute care to facilitate discharges over the weekend.

"We've educated them that we are a seven-day-a-week facility and that there will be discharges on Saturday and Sundays. They are working with us to help ensure that our patients get the post-acute services they need seven days a week," Salvo says.

*(For more information, contact **Ellen Salvo**, LCSW, Director, Case Management and Utilization, Brookhaven Memorial Hospital Medical Center; e-mail: esalvo @bmhmc.org.)* ■

Palliative care gets patients to right care level

Consult team works closely with case managers

At Summa Health System, hospital case managers, called patient care coordinators, often are the first people to alert the palliative care team when a patient could benefit from a consultation and the first people the team contacts to find out what's going on with a particular patient.

"Ultimately, palliative care gets the patients in the right place at the right time for the right level of care. We can collaborate with the patient care coordinators to facilitate their discharge plan by helping the family understand the options," says

Kim Kousaie, BSN, CHPN, director of Palliative Care and Hospice for Summa Health System.

Summa Health System is a nonprofit health care system in northeastern Ohio with three teaching hospitals and 1,235 licensed beds.

Palliative care is not typically reimbursed by insurance, but it can pay for itself by shortening hospital and intensive care stays, Kousaie points out.

The program is an outgrowth of Hospice of Summa, which includes a separate 12-bed palliative care unit and palliative consult service. The acute palliative care unit addresses patients' immediate needs until they are stable enough to go home or to another level of care. The average length of stay on that unit is three to five days.

At Summa Health System, the palliative care consult service has two nurse practitioners and two physicians and a palliative medicine fellow, who make between 120 and 130 new consultations each month with patients and family members on the medical-surgical units and intensive care unit.

They move around the hospital, assessing patients who might benefit from palliative care and facilitating medical and comfort care for patients.

The palliative care consult team consults on patients with a disease crisis who need symptom management and an interdisciplinary team to coordinate their care.

"Patients in palliative care have a serious or life-threatening illness and are looking at end-of-life issues, even if their illness won't become terminal for some time," Kousaie says.

When the palliative consult service started, the nurse practitioner and physician would attend the intensive care unit rounds and review with the team any patient who had been in the ICU for 14 days or longer.

In the rest of the hospital, the palliative care nurse practitioner works with the patient care coordinator, unit manager, social worker, and home care assessment nurse to review their patients and make recommendations when appropriate.

The palliative care team works with the treatment team and hospital staff to provide symptom management, patient and family support, comprehensive end-of-life care when appropriate, and discharge planning when patients can be moved to another level of care.

"We let them know when a patient is appropriate for palliative care. We've educated the hospital

CNE *questions*

13. Denials for medical necessity accounted for $391 million in overpayments discovered by the Recovery Audit Contractors during its pilot project. What percentage of the total amount that hospitals had to repay did this represent?

A. 40%
B. 35%
C. 50%
D. 28%

14. CMS says the majority of covered observation services can be completed in what time frame?

A. 48 hours
B. 60 hours
C. 24 hours
D. 18 hours

15. At Christus St. Vincent Hospital, an observation case manager reviews all patients in observation within what window of time after admission?

A. Eight to 12 hours
B. Twelve to 24 hours
C. Within 24 hours
D. Within 36 hours

16. At Brookhaven Memorial Hospital Medical Center, case managers are assigned to how many beds?

A. 20
B. 25
C. 15
D. 30

Answer key: 13. A; 14. C; 15. A; 16. C.

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. ■

staff so they understand that the palliative care team can help hold a discussion with the family that facilitates the discharge plan and gets patient moved to the palliative care unit or home with hospice services," Kousaie says.

To be eligible for a palliative care consultation, patients must have a life-threatening illness, such as cancer, end-stage heart failure, or a severe stroke.

"Our approach to palliative care is not limited to terminally ill patients. Our patients range from active treatment to noncurative care. Every care plan is unique," Kousaie says.

The team has recommended rehabilitation services for some patients with severe strokes. They've gone through rehabilitation and done well.

"We've had patients with end-stage liver disease who were on the transplant list and we managed their symptoms successfully until they had the transplant and moved on," Kousaie says.

The palliative care team gathers information from the patient's treatment team and meets with the family to present the options.

"When we are called in for a consultation, the patient care coordinator is the first person we see because they are aware of everything that is going on with the patient. They are the people who can give us information about family dynamics and other issues that may not appear in the chart," Kousaie says.

When the palliative care team meets with the patient and family members, it helps the patient and family members understand the meaning of what the physicians have told them, what it means for the patient in the future, what their treatment options are, and the likely outcomes of each option, she explains.

"The physicians sometimes lay out so many options that the family doesn't know what they are answering to. The physicians sometimes don't present the true scope of the long-term effect of the treatment. That's what palliative care does. We finish the sentence for the physician," Kousaie says.

For instance, a physician may say the next step

is a tracheotomy and a percutaneous endoscopic gastrostomy tube but the family may not understand that the process is only going to prolong the patient's life, not provide a cure.

"Nobody wants to tell a mother that giving her daughter more care is futile. We try to help the family understand what is happening and what the result of the each option is likely to be," she says.

Team educates family

The team educations the family on what "do not resuscitate" (DNR) orders mean, what comfort care means, and what they believe is likely to happen with the patient.

"We are a victim of our own success. We have been so successful at team meetings and at facilitating family meetings that we have almost enabled the physicians not to deal with end-of-life issues but to call us in instead," she says.

When the palliative care consult service began in 2001, the intensive care unit was its first target.

"It's the logical place to start. When the ICU fills up, the hospital may go on diversion and lose revenue, and sometimes there are patients in the ICU who do not benefit from additional treatment," she says.

The team started by looking at the mortality rate for patients who were in the intensive care unit for 14 days or longer.

"We determined that patient mortality could be predicted sometime between 14 and 30 days in the ICU," she says.

Part of the vision for the program was to educate the medical professional about the benefits of palliative care, Kousaie says.

The team put together an educational program about the benefits of palliative care and the services the consult program offered and presented at every medical and nursing department in the system.

"The patient care coordinators became the core group of people we focused on to educate them about what palliative care can offer and how it can help facilitate the discharge plan and get the patients moved to the right level of care. We wanted to educate them so when they work with patients who could benefit from palliative care, they'll have the information they need to approach the physician and ask for a palliative care consultation," she says.

The team continues to use every opportunity to educate the health care team about what palliative care means, she says.

CMs in position to make a difference

Even if their hospitals don't have a palliative care program, case managers are in a position to help patients and their families when situations arise where they may benefit from palliative care, Kousaie says.

"If case managers see a family struggling, they can talk to the family to get a sense of what they need, then present it to the physician, and suggest that palliative care might be appropriate," she says.

Gather all the information you can, talk to the family, and present the entire package to the physician.

Kousaie suggests that case management directors facilitate an inservice educational session on how to facilitate a family meeting.

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

- What to expect from an RAC audit
- Strategies for preventing rehospitalization, ED visits
- Patient status: Standardized process ensures medical necessity
- How interdisciplinary collaboration improves patient care
- Measure outcomes that support the CM program

"If case managers learn how to initiative those difficult conversations and feel comfortable talking about palliative care and end-of-life issues, it can be of great benefit and comfort to the patient and family," she says.

(For more information, contact ***Kim Kousaie****, BSN, CHPN, Director of Palliative Care and Hospice for Summa Health System; e-mail: KousaieK@summa-health.org.)* ■

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