HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

AHC Media LLC

IN THIS ISSUE

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Track your outcomes to justify adding new staff, avoiding budget cuts

Show your impact on patient care, bottom line

As more hospitals plan staff cuts due to the poor economy and tighter restrictions on reimbursement by the Centers for Medicare & Medicaid Services (CMS) and commercial insurers, case managers are challenged with determining how to demonstrate how their department positively affects the hospital's bottom line and to justify hiring new staff or avoiding staff cuts.

Case management directors frequently say they can't get approval to hire additional staff because it's difficult to show how case management brings value to the hospital as it is not a revenue-generating department, points out **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY.

"We are part of an interdisciplinary team that presents a package of care delivery to patients. The hospital may not bill directly for case management services, but we do bring value to the organization," Cesta says.

Case managers need to determine the right data to track and present those in a meaningful way to demonstrate the effectiveness of their program and to justify having enough staff to effectively complete the tasks they are expected to handle, she says.

"Few case management departments consider themselves fully and appropriately staffed," she adds.

Case managers today are challenged to coordinate care for sicker patients with fewer resources and are pressured to move them through the continuum quickly and develop a creative discharge plan that maximizes the available resources and prevents readmissions, says **Kathy Rickard**, RN, BSN, MBA, associate director, clinical resource management and social work at the Hospital of the University of Pennsylvania in Philadelphia.

"Case management is an increasingly complex and difficult job. We have more requirements from CMS and insurers, which add to the case

manager's daily workload, and we have to be able to demonstrate all that we do," she adds.

For instance, the requirement that patients receive the Important Message from Medicare informing them of their right to appeal their discharge takes a lot of the case manager's time.

"This is not a simple task. It involves discussion with the patient and family members to make sure they understand it. It's an additional part of everyone's responsibilities that has to be absorbed into our daily routine. It is challenging to do what was previously required when new government regulations add to the load," Rickard says.

Regulatory issues and CMs

Regulatory issues, such as the Important Message from Medicare, often are the responsibility of case managers and affect the hospital's compliance with Medicare's Conditions of Participation (CoPs), Cesta adds.

"Case managers can demonstrate the impact on the hospital's compliance with the Conditions of Participation. At the very least, case management directors can track how their work involves compliance issues to make the point that the case management department is not a closed department and that it brings value to the organization by ensuring compliance," she says.

Rickard's department tracks the number of patient contacts each case manager makes, the number of placements to various levels of care, the number of referrals for home health, and a variety of other performance measures and submits those to a benchmarking organization that compares the performance of the Hospital of the University of Pennsylvania to other academic medical centers.

The department provides the benchmarking information to the hospital administration to justify staffing levels when there is a need to fill an already budgeted position or to request additional FTEs when a new unit opens.

"The number of discharge planning assessments and the numbers of resources we set up for patients after discharge are keys in justifying the number of staff we have. The benchmarking data show that our staffing levels are on par with other hospitals that treat equally complex patients. Finance looks very carefully at the benchmarking data," Rickard says. **(For other ways that the Hospital of the University of Pennsylvania tracks and uses case management outcomes data, see related article on p. 84.)**

Process metrics were the first measures used in case management, and they still are useful to demonstrate productivity, Cesta points out.

Measure outcomes, not just processes

"Tabulating the number of patients a case manager or social worker touches, how many reviews they conduct, how many discharge plans they create — all are process metrics that indicate the

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volume of work. Productivity measures have been the foundation of how we identified the work of case managers; but today, we need to move beyond them from measuring a process to a measuring a true outcome," she says.

In order to begin demonstrating the benefits of what they do, case management departments should have a set of annual and short-term goals that mesh with the goals of their organization, Cesta says.

Look at the objectives of your department and what you are trying to achieve. Then determine the impact you are having on the organization and come up with ways to demonstrate the outcomes in a manner that other departments and disciplines can understand, she suggests.

When you create your case management outcomes report, don't use a lot of jargon that is specific to case management because others may not understand what you are saying, Cesta cautions.

Don't be redundant and report data that already are being reported by other departments.

"People are inundated with data. If you report the same data as another department, consider referring to the other department's data in your report," Cesta suggests.

As you put together a set of metrics to include in your outcomes report, write a definition for each metric and include a definition page in your report.

Make sure the data you report have meaning for your department as well as the organization as a whole, she adds.

Make sure that the metrics you report on are measurable and are under your control.

Some outcomes are affected by multiple departments and disciplines and are only partly under the control of case management, Cesta points out.

In your report, differentiate between the various types of case management outcomes and don't assume ownership of outcomes that are not entirely under your control, she suggests.

Make sure that your report points out that situations beyond the case manager's control can affect your outcomes in these areas, she says.

LOS comes first

"Length of stay is the No. 1 barometer in case management outcomes, but it is one of those metrics that is affected by virtually every department and discipline in the hospital. Typically, case management owns length of stay, but it is in fact affected by other departments," she says.

For instance, the clinical status of the patient and the case manager's ability to place the patient in another level of care are among the variables that affect length of stay.

Cost per day and cost per case are other outcomes that case managers affect through coordination of care but that ultimately fall back on the physician's order and the ability of the case manager to move the patient through the continuum, she says.

Although case management is responsible for denials reporting, other areas of the hospital have an impact on denials, she adds.

In reporting case management outcomes, find a balance between the clinical and financial outcomes, Cesta suggests.

"We do ourselves a disservice if we don't report both clinical and financial outcomes. The financial impact should be a clinical quality impact as well," she says.

In the hospital setting, the bottom line is not just financial but also includes the quality of care that patients receive, she points out.

For instance, delays in service can have an impact on quality of care as well as reimbursement because if a patient is not receiving services in a timely fashion, he or she is not receiving an appropriate level of care, Cesta says.

Inappropriate admissions affect quality because patients are not receiving appropriate care in the appropriate setting. They affect patient flow because nonacute patients are in an acute care bed, delaying acute patients from occupying the bed and creating a backlog in the emergency department.

"Patient satisfaction is also a quality outcome metric. Look at your hospital's patient satisfaction questions and make sure there are questions that are relevant to case management," Cesta suggests.

Track cost avoidance

Tracking cost avoidance is very important, Cesta points out.

"This is something that case managers do on a daily basis but don't give themselves credit for," she adds.

For instance, if your emergency department case managers avoid two "social admissions" each month at an average daily cost of $800 a day and a length of stay of two days, that saves $38,400 a year.

Another example is showing that case management facilitated the discharge of two patients per month, decreasing the length of stay by 2.5 days

at a savings of $48,000 a year.

"If you keep track of these, you can demonstrate quite a bit of revenue your department saves the hospital," Cesta adds.

Track your hospital's case mix index if your department is responsible for clinical documentation improvement and if you affect the reduction of inappropriate admissions, she says.

"Case mix index is another indicator that we watch to monitor the financial health of the hospital. So much work of case managers affects the case mix index, including stopping inappropriate admissions, ensuring that the documentation fully represents the patient's clinical status under the new MS-DRG system, and eliminating short stays," she says.

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Use data for operational changes, quality

Up-to-minute info allows you to head off trends

Case management outcomes can be a powerful tool for identifying the need for operational changes or process improvements throughout your hospital, as well as demonstrating the value of case management.

"By using our electronic case management system, we can track and trend data based on a variety of factors. Having up-to-the-minute data enables us to respond more quickly and try to head off trends that would be difficult for our hospital financially," says **Kathy Rickard**, RN, BSN, MBA, associate director, clinical resource management and social work at the Hospital of the University of Pennsylvania.

An electronic data management system is the key to being able to analyze data and create reports in a timely manner, she adds.

"We used to collect information on paper and cobble together a report. Now our ability to document concurrently and analyze data electronically has enabled us to notice trends and respond much more quickly than in the past," Rickard says.

Analyze your denials data to determine which physicians have a high number of denials and track denials by payer to determine if there are arbitrary denials; pass on the information to your finance department to use during managed care contracting, suggests **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY.

At the Hospital of the University of Pennsylvania, the clinical resource management department tracks denial patterns and obtains information on the cost of denials on a monthly basis from the business office. The information is used to spot trends among physicians or payers and take steps to correct problems, Rickard says.

"We break it down so individual physicians can see exactly what their performance is and the cost of the denials. We show them whether they had denied days or if the entire course of care was denied by the insurer," she explains.

Track denials

The department notifies the hospital's managed care contracting staff when the hospital is getting denials from a particular insurer for a condition or procedure for which it previously was approved.

Measure the effect your physician advisor has on denials as well, Cesta says. Track the intervention of the physician advisor and whether he or she had an impact on getting it reversed.

You can determine the dollar amounts and what department is involved.

If you don't have a cost accounting system, it's impossible to determine the costs that case management has affected. Work with your financial department to determine the cost of care and use that to demonstrate an overall reduction of cost where case managers affected patient flow, length of stay, and resource utilization, she suggests.

At the Hospital of the University of Pennsylvania, the clinical resource coordinators go on daily rounds and notify the treatment team if an insurer is denying or downgrading a case.

"The clinical resource coordinators also work with the physician advisor to get any additional information needed that would keep the case from being denied. They work with the treatment team to get the patient on the right level of care as quickly as possible," Rickard says.

The department does the same with avoidable

days, creating reports for physicians and working with them to align the resources and decrease avoidable days, she says.

Case managers should track avoidable days on a daily basis, by identifying gaps in care or delays in service through their own review process while they are making rounds, Cesta says.

Categories in your avoidable day report could include: internal system delays, such as waiting for an operating room; external delays caused by lack of available resources in the community; payer delays; and physician delays.

Break down your data. For instance, include a chart that shows the reasons for avoidable days. Break it down into categories, such as patient/family (no rehab coverage; family can't be reached, etc.); payer (Medicaid pending, insurance issues); and provider (delay in switching from IV to PO medication, covering MD will not discharge patients).

Drill down to understand the causes of delays and break them down into the time of day or time of the week. For instance, patients waiting for a particular service over the weekend affects length of stay as well as cost, Cesta says.

Administration can use the information you provide to make changes, such as considering extending the hours of the cardiac catheterization lab.

"Insurers expect a hospital to provide all the services 24 hours a day, seven days a week. It's a balancing act to figure out which services we need to have available. We track when certain procedures don't happen on the weekends and use the data to determine if it's physically and financially possible to increase the hours of that particular service," Rickard says.

Discharge delays may be due to the lack of resources in the community or the patient's inability to pay for them, or because physicians are not discharging patients in a timely manner, Cesta points out.

"Keep track of delays that are outside the control of the case management department but have an impact on your outcomes," she says.

Inappropriate admissions are going to be a focus of quality improvement organizations in the future, Cesta says.

Break out the inappropriate admissions from your denials and take a broader look at them and the impact they have on an organization, she suggests.

"A lot of times patients are admitted inappropriately for social reasons and the case managers have problems discharging them to a safe environment," she says.

Inappropriate admissions affect patient safety because nonacute patients are exposed to an acute care environment, she adds.

Use the data you collect to make changes in your case management procedures, Cesta suggests. For instance, although Medicare doesn't define the length of observation but says it expects in the majority of cases that the physician can make the decision about whether to admit the patient within 24 hours.

"If a hospital is exceeding 24 hours in observation in the majority of cases, the case management department should determine why and make changes. It's not good for the patients or for the hospital in general," she says.

Readmissions or emergency department visits are affected by other departments in the hospital but have relevance to case management, Cesta says.

Rickard's department tracks readmissions using a web-based tool that provides timely information about readmissions, which the case management team uses to find the cause of the readmissions and determine ways to prevent them in the future.

"Directors of case management need to know why patients are returning to the hospital because it may be an indicator of a failed discharge plan," Cesta says.

She suggests that case management directors review patients who are readmitted within 24 hours, the next day, within 15 days, and within 30 days and drill down to determine why the readmissions occurred. ■

Pre-admissions screening helps cut readmission rate

Discharge planning begins before the hospital stay

A pre-admission screening and educational program for patients having elective surgery has helped slash readmissions among patients treated at Geisinger Health System from nearly 20% a year ago to about 10% today.

"One of the big keys in preventing readmissions is knowing in advance that patients are at high risk for readmission and working with them and their family members to overcome the challenge. We have expanded the walls of the hospital to provide pre-admission assessment and testing and

post-admission follow up," says **Susan Standish Wallace**, MS, RN, MCCL, NE-BC, director of care management for the health system with headquarters in Danville, PA.

As length of stay has decreased, it has become challenging for care managers to complete the teaching that patients need in order to take care of themselves after discharge, Wallace points out.

"Today, our patients heal and recover in other settings — in rehabilitation facilities, long-term care hospitals, or at home. Our efforts to teach the patient how to handle his or her illness has to stretch beyond the limits of the hospital stay," she adds.

A few years ago, the average length of stay at Geisinger was seven to eight days. This enabled the care managers to start post-discharge education on Day 6 or 7, when the patients were feeling well enough to learn.

"Now our average length of stay for all DRGs is less than five days. Even though the length of stay is shorter, patients' needs are the same," Wallace says.

Discharging elderly patients

Many elderly patients have multiple comorbidities, which make their post-discharge needs more acute. In addition, anesthesia tends to stay in the system of geriatric patients for a long time, making it difficult for them to comprehend post-discharge education while they are in the hospital, Wallace points out.

The problem is compounded for patients who live in rural areas, some as far as 300 miles from the hospital. Since rural home health agencies and nursing homes have limited capacities, taking a proactive approach to discharge planning and giving the agencies a heads up early in the hospital stay helps the care managers meet the patients' post-discharge need in a timely manner, she adds.

At Geisinger, patients who are coming in for elective total joint replacement surgery and the majority of those scheduled for elective general surgery receive a risk assessment and a comprehensive screening and education call before admission.

The information lets the care managers who will coordinate care for the patients after admission, get a head start on discharge planning, and work to overcome obstacles and challenges to a timely discharge.

"Pre-screening patients helps us identify patients who may have difficulty learning how to care for themselves after discharge and to identify a family member or caregiver who can be here for the teaching prior to discharge," Wallace says.

Patients who are having elective total joint replacement surgery complete a risk assessment form in advance and attend a class that helps them understand their surgery and what they will need after discharge.

When patients receiving elective general surgery go to the clinic for their preoperative visit, clinic staff complete a risk assessment form and pass the information on to the hospital staff. **(For details on the general surgery and joint replacement initiatives, see related articles on p. 89 and p. 90.)**

Patients in both categories also receive a pre-admission screening call that helps them understand what kind of assistance they will need after discharge.

Before patients are admitted for surgery, **Cynthia Faust**, LPN, calls them at home and gathers additional information, which she places in the medical record; the unit-based case managers can follow up with more teaching and transition planning while the patient is in the hospital.

Faust makes sure the patients understand that they will need someone to stay with them and that they need to make arrangements in advance for their pets if there could be an issue in their care.

"I make sure they have someone lined up who can get their groceries and medication during the time they can't drive so they have adequate supplies of things they might need, like diabetic test strips," she says.

When patients live alone, Faust identifies someone who could care for them after discharge and calls to ensure that the person will be available.

In addition, care managers on the unit make sure that patients have scheduled follow-up visits with their primary care physicians before they leave the hospital.

"Research has shown that it is important for a patient being transitioned from the hospital setting to be seen by their primary care provider within 72 hours and that the longer the time they wait before their primary care visit, the bigger the risk that the patient will return to the emergency department or be readmitted," Wallace says.

Geisinger's hospitalists alert patients' primary care physicians about the hospital visit within a few days after discharge. In many cases, the hospitalist

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CRITICAL PATH NETWORK™

Culture change turns hospital system around

Process ensures that patients meet medical necessity criteria

A few years ago, Christus Santa Rosa Hospital in San Antonio was $80 million in the red and was compliant with medical necessity and appropriateness of care criteria only 62% of the time, according to audits by the hospital's quality improvement organization (QIO).

That was 2001. In 2008, the hospital system received a 92% compliance rating and was named one of the best 50 hospitals in the nation by HealthGrades for the sixth year in a row. At a 6.8% rate for converting patients from observation to inpatient status, the hospital is well below the national benchmark of 25%.

Turning the hospital system around required a complete culture change in the hospital and in the community, says **Roxanne Jenkins**, RN, regional director, care management/accreditation compliance for Christus Santa Rosa, a nonprofit, faith-based health system with four facilities in southern Texas.

"We provide a large charity benefit. However, the community's perception was that we should provide all of the charity care without regard to the cost of care. We had many patients who didn't meet admission criteria and a lot of social admissions. We had to educate the community that 'no margin, no mission.' That is very difficult for us, as our mission is to extend the healing ministry of Jesus Christ," she says.

When Jenkins arrived at the health system's flagship hospital, Christus Santa Rosa, in 2001, there was a lack of a care management program and no method for determining medical necessity or appropriateness of care.

In addition to caring for indigent patients, the hospital system was subject to a quarterly review by the QIO and was only 62% compliant, which meant that the hospital had to pay back the erroneous reimbursement in 38% of cases.

"We needed a gatekeeper up front so we would get the patient in the right status at the beginning and wouldn't have to clean up on the back end. Many hospitals put their gatekeepers in the emergency department, but we are a multisite hospital, and the cost of putting someone in the emergency department or admitting department at each site would not be beneficial," Jenkins explains.

Patient intake center makes difference

A key to the hospital's success was the creation of a patient intake center, staffed by experienced RN case managers with backgrounds in acute care case management who are responsible for reviewing the admission and the status of every patient admitted to the four facilities in the health system. The patient intake center, located at Christus Santa Rosa, is staffed 24 hours a day, seven days a week. **(For details on the patient intake center and how it operates, see related article on p. 89.)**

"We couldn't just open the patient intake center. We had to make a lot of operational changes and change the culture of the practice at the hospital and that took a lot of work up front. This could not have happened without the full support of the administration and the corporate leaders," Jenkins says.

The hospital administration appointed an interdisciplinary revenue cycle/denials team with representatives from financial services,

admission and registration, and care management and added ad hoc members if there was an issue that they could affect.

The team started by analyzing data for opportunities to change or improve the processes.

The team analyzed denials and drilled down to determine the reasons for the denials. It sorted denials by physician, service line, diagnosis, admission status, and level of care.

"We started trending and identifying patterns and opportunities to change or improve processes. The administration was amazed by our findings. We knew from our QIO's quarterly review that many patients did not meet admission criteria and that we had far too many one-day stays," Jenkins says.

Many of the denials were because the admission didn't meet medical necessity criteria or because the status was inappropriate.

In the past, physicians often allowed patients who were ready for discharge on Friday to stay over the weekend or admitted them for three days to meet the Medicare criteria for transfer to a skilled nursing facility.

"We also found that we were experiencing a high number of one-day stays, some of which should have been outpatient procedures," she says.

At the time, doctors would routinely admit indigent patients to Christus Santa Rosa for outpatient diagnostics if they knew the patient couldn't pay.

"We were losing a lot of money this way. Now we offer to assist patients in scheduling the outpatient diagnostic procedure and offer financial counseling and charity care," Jenkins reports.

Drilling down

The team drilled down and discovered that other hospitals in the community were transferring their unfunded patients although the referring hospital could provide the same services and the same level of care.

"There was dumping going on. That needed to cease immediately," Jenkins says.

One of the main facilities is in downtown San Antonio where there are a lot of homeless patients. Many homeless patients would come to the hospital when it was cold outside and get a bed and meals.

"We wanted to do what's good in our hearts but we are a health care facility and we need to take care of those who are suffering from health care conditions and who meet the criteria," she says.

Jenkins made a proposal to leadership for changes in how the hospital operates.

"We knew that we needed to meet national benchmarks and institute evidence-based practices, and to do that we had to change physician practice patterns and the culture of thinking that the hospital could be everything to everybody no matter what they needed," she says.

In addition to creating the patient intake center, the hospital enhanced and structured the inpatient care management department to follow up on admissions and ensure that patients continue to meet inpatient criteria and move safely and appropriately through the continuum of care.

The hospital's computerized admissions system allows the patient intake center to notify the case managers of all admissions that need a follow-up.

The team also drilled down on organizational reports to review denials, one-day stays, and observation patients to find the opportunities that might impede them from reaching their goals and to develop procedures to overcome the barriers.

"We tried to foresee every barrier and eliminate that barrier. When we had an inappropriate admission, we looked at what we could do to prevent it from happening again," she says.

"We spent months communicating with and educating the physicians and their office staffs, the hospital staffs, and the referring hospitals about our new process and the reasons for it. We put our changes in a positive light for physicians, telling them that we wanted to institute best practices and to help their patients get the care they need," she says.

The hospital team invited the office managers and nurses at physician practices to lunch to promote a smooth admission process between the offices and the hospital and followed up by delivering baskets of cookies and fruit to the offices along with Rolodex cards with the phone number of the patient intake center.

The team offered continuing education credit "lunch-and-learn" sessions for the physicians. The information provided on integrity and compliance met the requirements for the physicians' CME credits on ethics.

"We spoke at every medical staff committee, focusing on best practices, rather than making changes to affect the hospital's financial health. We enlisted their help in becoming the best facility in the area. That's what helped change the culture,"

Jenkins recalls.

The hospital compiled data that showed which physicians were admitting patients whose cases were not reimbursed due to medical necessity and/or patient status and enlisted the aid of physician champions from the performance improvement teams of each facility to educate the physician outliers one on one.

"We informed the physicians of the scrutiny we were getting from regulatory agencies and provided education on how this would affect our quality outcomes now and in the future. We wanted to partner with them so it would be a win-win situation for all of us. The physicians were reluctant at first, but many of them have expressed their gratitude now that CMS [the Centers for Medicare & Medicaid Services] is looking at their billing as well," she says.

(For more information, contact: ***Roxanne Jenkins****, RN, Regional Director, Care Management/Accreditation Compliance for Christus Santa Rosa. E-mail: roxanne.jenkins@christushealth.org.)* ■

Patient intake center operates 24-7

Protocol allows RNs to make admission decision

Every admission to any of the four facilities in the Christus Santa Rosa health system goes through a central patient intake center where RN case managers screen for medical necessity and appropriateness of care and determine patient status.

"We have one central location that services all the facilities and processes every admission, including the transfers. We know up front whether the patient is in observation or to be admitted as an inpatient and whether he or she needs a telemetry, medical-surgical, or intensive care bed," says **Roxanne Jenkins**, RN, regional director, care management/accreditation compliance for the San Antonio-based health system.

The patient intake center has had a major impact on reducing denials, reducing inappropriate observation status classifications, and assuring appropriate level of care, she adds.

Denials dropped from 3.6% of net patient revenue in fiscal year 2001 to 0.7% in FY 2008. The hospital experienced no denials related to medical necessity in 2007, 2008, or so far this year, Jenkins reports.

The patient intake center is staffed 24 hours a day, 365 days a year by experienced RNs who are trained in admissions criteria. The hospital system uses both InterQual and Milliman criteria to meet the requirements of the complex list of managed care payers in the area.

"We have a large pediatric population as well as Medicaid managed care, and not all payers use the same criteria," Jenkins says.

The patient intake center takes a three-pronged approach. The nurses look for medical necessity for inpatient admissions, whether the patient might meet observation criteria or need outpatient treatment.

The hospital system has developed protocols approved by the medical staff that allow the patient intake center case managers to suggest the admission status using evidence-based criteria. They place the orders on the chart with the approval of the admitting physician and the physician signs them on their next visit.

If patients don't meet acute care admission criteria, the nurses suggest an alternative level of care.

"Our social workers and case managers in the hospital can provide a resource list and contact information for LTACHs, home health, durable medical equipment, or whatever the patient needs," she says.

Before the new system was instituted, hospitals in the area would routinely transfer patients to Santa Rosa if they had no funding sources because of the impression that the hospital was supposed to provide the charity care in the community.

Now hospitals that want to transfer patients to Christus Santa Rosa have to fax clinical information and data to show that the patient needs a higher level of care or service than the transferring facility can provide.

If patients don't need a higher level of care or service, the patient intake center nurses can deny the transfer.

For the first 18 months of the new process, denials of transfers had to go through the administrator on call. The department would follow up the next day with a letter explaining that the patient who was denied a transfer didn't need a higher level of care or service than the transferring hospital could provide.

"In the beginning, we woke up a lot of administrators. Now, when the PIC nurses cannot see the need for our services, they have the authority from the administration to deny a request for a transfer," she says.

Before the patient intake center was opened, nurses and office managers from physician offices might call the admission office, the nursing supervisor, or the nurse managers on the floor to get a patient admitted. Sometimes, patients would show up in the emergency department saying their doctor told them they were being admitted and no one in the hospital was aware of it.

"There was a lack of organization for the admission process," she says.

Now the physician's office staff have just one number to call. They fax in the patient's clinical information to the PIC nurse who screens the patient for admission criteria.

The patient's registration information already is in the hospital computer system when he or she arrives.

When a patient presents to the emergency department, he or she is triaged and treated by the emergency department physician, who notifies the patient intake center if an admission is required. The nurses can access all the clinical data on the computer and make a decision on whether the patient meets admission criteria. The PIC nurse reviews the data for the admission, based on criteria for medical necessity.

"The PIC continues to serve Christus Santa Rosa's four facilities and will soon expand to five," Jenkins says. ■

Pre-op initiatives aid discharge planning

Patients attend class, screened before surgery

One patient who was attending a preoperative class for joint replacement patients at Geisinger Health System joked that he was being discharged before he ever got to the hospital, recalls **Trisha Whispell**, BSN, MSW, ACS, social work care manager, who, with her RN care manager partner, presents a pre-admission class on joint replacement and manages care for patients after surgery.

Patients who are scheduled for elective joint replacement surgery within three or four weeks and their family members attend the classes. The entire team that will be involved with patient care educates those patients on what to expect during and after their hospital stay. The team includes an orthopedic surgeon, a physical therapist, a pharmacist who educates patients on warfarin, and a member of the health system's blood conservation team.

The last 20 minutes of the class focus on transition planning — moving patients through the system from pre-admission until discharge, Whispell says.

She goes over medical equipment needs, insurance matters, care that the family will need to provide after discharge, and the need for transportation from the hospital.

"Discharge planning is a big piece of the program. The patients fill out a questionnaire before the class telling who they live with, how their home is set up, how many steps they will have to climb, how accessible the bathroom is, and other information on what the patient will need to be discharged safely to home," she says.

The team encourages the patients to have a post-discharge plan as well as a backup plan in case there are complications.

For instance, patients may prefer to go home with visiting nurses or outpatient therapy, but their backup plan would be a short stay in a rehab or skilled nursing facility.

The pre-admission classes have increased family involvement as well as patient satisfaction, Whispell says.

Getting the information about discharge needs up front gives the patient and family members an opportunity to start discussing issues and concerns before the surgery occurs, she says.

"We want them to be prepared for anything that might happen. The length of stay for elective joint replacement is usually two to three days. When patients are not screened up front and don't have discharge plans prepared in advance, it can result in a longer length of stay and a lot of stress for the family, which has to make last-minute plans," Whispell explains.

Patients who are having a second joint replacement surgery may omit the program, but they still get a pre-admission screening call.

Patients who can't attend the class receive a video of it. Spanish-speaking patients receive a version that is dubbed in Spanish.

Patients who are insured by Geisinger Health Plan and are having elective joint replacement surgery receive a free physical therapy assessment in their home prior to admission.

"The physical therapists are our eyes in the home. They often pick up on potential problems and send us a note or call us. They begin teaching the patients to use the crutches or walkers to navigate around their home," Whispell says. ■

(Continued from page 86)

at Geisinger calls the primary care physician to update him or her on the patient's condition.

The hospital is working on a pilot project to e-mail a brief synopsis of the discharge summary to the primary care physician on the day of discharge.

In addition, patients who are chronically ill and at high risk for readmission are referred to Geisinger's advanced medical home (also known as ProvenHealth Navigator), a community-based pilot program whereby Geisinger embeds RNs in physician practices to closely follow chronically ill patients. Some of the patients receive home monitoring equipment with which to record their blood pressure, blood sugar level, weight gain, and other vital signs. The information is transmitted to the doctor's office where the staff can intervene if necessary to help the patient avoid a visit to the emergency department or a readmission.

"With unscheduled admissions, we're working on doing a better job of evaluating patient learning. Our nurses, physicians, and care managers use a teach-back method to make sure that patients understand their post-discharge instructions," she says.

Using the "teach-back" method, staff ask the patient to repeat the information and tell them why it's important.

(For more information, contact: ***Susan Standish Wallace****, RN, MCCL, NE-BC, Director of Care Management, Geisinger Health System. E-mail: smwallace@geisinger.edu.)* ■

Surg patients pre-screened for discharge issues pre-op

Clinics, hospital staff work to prevent readmissions

By the time the majority of patients having elective surgery are admitted to Geisinger Health System, the care managers who will coordinate their care after surgery already have the information they need to create a discharge plan.

The hospital system began its program to reduce readmission rates for the majority of patients having elective general surgery in May 2008. Patients eligible for the program are undergoing gastric bypass surgery, oncological surgery, bowel resections, and other general surgeries.

When these patients visit the clinic for their preoperative appointment, the clinical nurse specialists complete a risk assessment screening that includes questions about age, living situation, mobility issues, the number of medications, and any hospital or emergency department visits in the past 12 months.

"What makes this process different is that the hospital is coordinating with the clinic prior to admission. We take the information gathered in the clinic and follow up in the hospital and as the patient transitions to the community," says **Heide Feele**, MSW, ACS, social work care coordinator who partners with an RN care manager to coordinate care for patients on the surgical floor.

The hospital care coordinators receive information on patients who are at high risk for readmission before patients have surgery.

"When the patient is on our floor, we use that information and the information from the preadmission screening calls when we follow up with the patients after admission. If there is likely to be a discharge issue, we can take care of it before admission," Feele says.

For instance, rural home care agencies typically have a two to three day waiting list. When patients are coming from those areas, the care managers call the agencies on the day of surgery and give them a heads up so a nurse will be available to see them at home when they are discharged, Feele says.

The care managers see patients on the surgical unit on the day following surgery. "Some of the patients go to the ICU or a telemetry unit. They're not fully included in the project unless they come on our floor," she says.

Using flowsheets

The goal is to expand the pilot program to the special care and telemetry floors and to include all patients who receive scheduled surgery.

The care managers follow patients until discharge using flowsheets that include clinical milestones for each day of admission. The nursing staff use similar flowsheets.

"We focus a lot on the support system at home and their chronic medical conditions. We get physical therapy and occupational therapy consults ordered as early as possible and spend a lot of time educating them on wound care, drain care, and other needs they will have after discharge," she says.

The teaching on the floor is reinforced by the

home care agency, she says.

The care managers help the patients and families have realistic expectations of the care they will receive after discharge.

"Some patients think that when they go home, a nurse will come out once or twice a day. We educate them on the care they will have to provide on their own," she says.

When patients unexpectedly need to spend time in a skilled nursing facility, the team can give them a virtual tour of facilities on a laptop computer. ■

AMBULATORY CARE
QUARTERLY

Diversion scheme draws national organizations' ire

Hospital might reconsider its policy

Several EDs across the country have initiated policies to encourage patients who don't face "true" emergencies to seek care elsewhere in the community and to find "medical homes," but none have been met with the outrage that descended upon the University of Chicago Medical Center recently. *The Chicago Tribune* reported that under a new policy, the hospital was "escalating steps to direct these consumers elsewhere, which it says will allow it to focus on treating the sickest of patients."[1]

Reaction from within the industry was swift and uncompromising. In a prepared statement, leaders of the American College of Emergency Physicians (ACEP) said the university was "dangerously close" to a "patient-dumping" policy that would violate the Emergency Medical Treatment and Labor Act (EMTALA). ACEP said that several emergency physicians and the ED director resigned over the new policy.

The American Academy of Emergency Medicine (AAEM) said the University of Chicago should "re-evaluate its triage and screening examination policies."

As this issue went to press, an internal hospital memo indicated the facility was, indeed, "reconsidering" its policy,[2] but ACEP and AEEM leaders remained skeptical. What's more, they say, such a re-evaluation would not negate some of the actions already taken. They also expressed concern that other facilities, facing growing financial pressures, might consider similar actions.

"It's good that they're listening to public constructive criticism, and perhaps even listening to their own ED physicians and nurses, whereas initially this was done without any input from clinical people," notes **Larry D. Weiss**, MD, JD, FAAEM, president of the AAEM, a professor of emergency medicine at the University of Maryland in Baltimore, and an attending ED physician at the University of Maryland Medical Center. "Several of our members who work there said they were not considered at all — that the policy was developed by administrative personnel," he says. Such an approach is tantamount to "changing the way the operating room works without consulting the surgeons," Weiss adds.

Weiss' objections extend to the new triage policy itself. "It's our understanding that if, during the screening exam, the physician determines the patient to be stable, they are directed to discharge them," he says. "But there are many stable patients who require admission, and the idea that they would turn away stable patients violates national standards of practice." For example, Weiss offers, a patient with a gallstone could be in a lot of pain but not have an infection, or someone with pneumonia might have stable vital signs. "Where do you draw the line?" he asks.

University's plan went too far

What the University of Chicago was doing went beyond what many other facilities have done, says **Sandra Schneider**, MD, an ACEP vice president. "What they did was, in order to maintain their financial status, they looked at the types of patients that added dollars to the hospital and made inpatient beds available to them while cutting down on the number of beds available to regular emergency treatment," says Schneider, who also is a professor of emergency medicine at the University of Rochester (NY) and an attending ED physician at Strong Memorial Hospital, also in Rochester.

Schneider says such a policy might not violate EMTALA, as long as the patients who are diverted don't have an emergency medical condition. However, there is a moral obligation to see them, she says. **(One legal expert says EMTALA concerns may be real. See the story on p. 94.)** Schneider argues that most of these patients are not "taking advantage" of the ED, which many

assert is the case. "Our literature shows us that many of these people do not go on to get treatment," she says. "Those who choose to come to the ED often do so because there is no other option, either there are no clinics available or those that are available are not open at the times they can get there."

As for the latest news about the hospital, "we do not know what they have come up with, although we're happy they are reconsidering the policy," says Schneider, who adds, "We'd be glad to meet with them and talk about it."

References

1. National Center for Policy Analysis. U. of C. emergency room to get more selective: New version of patient triage aims to cope with spiraling costs and long waits for treatment. Dallas; 2009. Accessed at www.ncpa.org/sub/dpd/index.php?Article_ID=17570.

2. Louden K. Chicago hospital to halt new emergency department policies after criticism. *Medscape Medical News*, March 16, 2009. Accessed at www.medscape.com/viewarticle/589704. ■

Hospital's plan — a bridge too far?

While it's true that many hospitals and EDs have instituted policies that seek to encourage nonurgent patients to find other medical "homes," the policy recently adopted at the University of Chicago Medical Center goes a bit farther than most, says **Sandra Schneider**, MD, vice president of the American College of Emergency Physicians.

"Many hospitals are doing something similar, but perhaps not as overt or as obvious," says Schneider, who also is a professor of emergency medicine at the University of Rochester (NY) and an attending ED physician at Strong Memorial Hospital in Rochester. "Many, for example, will choose to admit patients who have surgical needs to the OR over those from the ED, if there is one bed left in the hospital." She also has seen hospitals continue to take transfer patients even when the facility is full and patients are waiting in the ED, "because transfers usually pay better, have insurance more often, and have more complex issues," Schneider says.

Where the University of Chicago was a bit more overt about it, she asserts, is they began to shrink beds available to patients and the size of the ED, "which artificially reduces your ability to take in patients who cannot pay. It's one way to make sure you do not get those types of patients." What's more, such an approach is based on a misconception, says **Michael Frank**, MD, JD, FACEP,

CNE *questions*

21. According to Toni Cesta, PhD, RN, FAAN, what is the No. 1 barometer in case management outcomes?
A. Avoidable days
B. Length of stay
C. Cost per case
D. Core Measures compliance

22. Cesta recommends that case management directors track readmissions that occur within 24 hours after discharge, the next day, within 15 days, and within 30 days and drill down to determine their cause.
A. True
B. False

23. By assessing and educating patients before they are admitted for elective surgery, Geisinger Health System has cut readmissions from 20% to:
A. 10%
B. 12%
C. 15%
D. 5%

24. According to Susan Standish Wallace, MS, RN, MCCL, NE-BC, research has shown that patients should be seen by their primary care physician within how many hours after discharge from the acute care hospital?
A. 24 hours
B. 36 hours
C. 48 hours
D. 72 hours

Answer key: 21. B; 22. A; 23. A; 24. D.

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. **The semester ends with this issue.** You must complete the evaluation form provided in this issue and return it in the reply envelope provided to receive a credit letter. ■

FCLM, general counsel and director of risk management for Emergency Medicine Physicians Management Group, in Canton, OH. "Editorial in the *Chicago Tribune* to support this policy cited average costs of $1,200 for an ED visit to demonstrate that the hospital can't afford nonurgent visits," he notes. "That may be what they charge, but that's not what the visit costs the hospital."

Hospitals, he notes, have many fixed costs, including utilities and salaries. "What it costs to treat someone with a sore throat is trivial," Frank says. "If you divert that patient, you may save $20, not $1,200." ■

Beware of EMTALA, warns legal expert

Hospitals and EDs that institute policies similar to the recent approach instituted at the University of Chicago Medical Center would do well to consider that they may be in violation of the Emergency Medical Treatment and Labor Act (EMTALA), warns **Michael Frank**, MD, JD, FACEP, FCLM, general counsel and director of risk management for Emergency Medicine Physicians (EMP) Management Group in Canton, OH.

"You can form a system that will result in ED patients going elsewhere, once it has been determined they do not have an emergency medical condition that will comply with EMTALA, but it's very difficult to do that — and very hazardous — because the standard that is used will be retroactively applied," he says.

EMTALA requires an "appropriate" medical screening exam (MSE), he says. "But the term 'appropriate' has never been defined by CMS [the Centers for Medicare & Medicaid Services] or any other group, so this is a wide-open invitation for CMS to determine, after the fact, that the diverted patient did have an emergency condition," Frank says. "They could also determine that the screening was not appropriate."

Frank says his understanding is that the facility was doing appropriate triage, but not necessarily an assessment. "I don't think they were only using physicians," he notes. "Under CMS guidelines, the hospital must use 'the full spectrum of its capabilities' in performing a medical screening exam." So, Frank explains, "If you have doctors in the ED, which is part of the 'full spectrum,' it becomes problematic to say you have done an appropriate MSE when it is done with nurses and paramedics and you don't use doctors."

The bottom line is that while such policies can follow the letter of the law, they still are risky, he says. "There's no way to be sure you will not run afoul of EMTALA with such a policy," Frank warns. "All it will take is one complaint, and EMTALA is complaint-driven." ■

'Seniors-only' ED draws raves from patients

Revamping existing space kept down costs

The senior emergency center at Holy Cross Hospital in Silver Spring, MD, may be a rarity, but based on the responses of patients and staff — not to mention our increasingly aging population — perhaps more EDs should consider creating a separate unit for older patients.

"Since we opened [in November 2008], we have averaged between 97% and 99% in patient satisfaction," reports **Bonnie Mahon**, RN, BSN, MSN, senior director of medical, surgical, and senior services. **(The unit was designed by a multidisciplinary team including ED representatives. See the story, p. 95.)**

David Cummings, RN, CEN, Holy Cross emergency center director, says, "Based on the patient responses, they are very appreciative of being placed outside the general ED population in a quiet area where the staff are more attuned to their specific needs." **(Members of the regular ED staff volunteered to work in this new unit. See the story on p. 95.)**

The senior center is located within the ED itself. The space formerly was used for express care, which has been moved to another floor. The senior center has its own entrance and exit doors. All patients present in the main triage area of the ED. At that point, a set of criteria are used to determine if they should be placed in the senior center. First, they must be age 65 or older. Secondly, their placement is determined by the initial symptoms.

They use a scale of 1 to 5, Mahon explains. "If they are clutching their chest, for example, and are possibly having an MI, they are Category 1 and are immediately taken back to the acute side of the ED," she says. If MI, stroke, and acute bleeding are ruled out, which puts them in Categories 2 to 5, they are eligible for the senior emergency center.

Once the patients are placed in a room, the primary nurse conducts a six-question assessment. The assessment includes issues such as history of falls, the last time they were in an ED, and their current medications. "We want to see if they are at risk for return," Mahon explains.

If a patient responds positively to five or more questions, the nurse puts in a request for a pharmacy consult, Mahon says. "The pharmacist will review all the medications," she says. "We have had several 'saves' since we opened." For example, Mahon recalls a patient who came into the ED after falling. A review of the medications indicated the dosage level was too high, so adjustments were made. "We consider that a save," she says. A score of 2 or more triggers a visit from a social worker, Mahon adds.

Two weeks after discharge, a coordinator in the hospital's office of seniors conducts a follow-up survey. The survey asks patients how well the staff listened to them, if they were kept well informed, how they would rate the care and compassion with which they were treated, what they thought about noise levels, and if they would recommend the facility. ■

Multi-unit team designs senior ED

Once the decision was made in July 2007 to create a senior emergency center at Holy Cross Hospital in Silver Spring, MD, **Bonnie Mahon**, RN, BSN, MSN, senior director of medical, surgical, and senior services, put together a team that included two ED physicians, the chief nurse, the nurse manager, and a director of case management.

Fortunately, there was space available within the ED itself to create a separate department. "We just knocked down a wall," she says. "It had its own nurses' station, six bays, and two rooms."

The team changed the lighting based on the recommendations of elder care expert **Bill H. Thomas**, MD, and his colleagues from the University of Maryland Baltimore County Erickson School. The school offers a major in management of aging services, and it describes itself as "part business school, part aging studies, and part public policy."

"Their specialty is aging," says Mahon. Upon their recommendation, the shiny linoleum floors were replaced with nonskid faux wood. Light dimmers were placed in all bays, with switches in the nurses' stations. "Normal fluorescent lighting creates 'hot spots' on the floors that can affect depth perception and cause falls," she explains. The walls were painted in warm colors such as gold, and all rooms or bays have a clock and/or a TV.

The renovations cost a total of $150,000, Mahon reports. "We were very fortunate that in 2007, the hospital fundraiser was dedicated to seniors, so the money raised went toward creating the center," she says. ■

ED staff volunteer for senior center

Most of the staff in the new senior emergency center at Holy Cross Hospital in Silver Spring, MD, came from the main ED, says **David Cummings**, RN, CEN, the hospital's emergency center director.

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

- How to prepare for an RAC audit
- Taking case management to the community
- Strategies for improving patient flow
- Forging good relationships with the treatment team

"What we have done is find people who really want to work with this population and ask them to work there permanently," he says, noting that it is similar to what happens with a pediatric ED. "In 'peds,' you have mostly pediatric RNs, which is a subspecialty, and we created a subspecialty of nurses who are interested in and understand the needs of the population," Cummings says.

This unit did not leave the main ED understaffed, he says. "This was an area that was previously staffed that we carved out, so people were just differently assigned," Cummings explains. ■