# HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

AHC Media LLC


## IN THIS ISSUE




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# Case management affects bottom line, quality of care, regulatory compliance

*Challenges, opportunities abound in today's health care market*

Hospital reimbursement is being squeezed from all sides. In the proposed Inpatient Prospective Payment System rule for fiscal year 2010, the Centers for Medicare & Medicaid Services (CMS) has proposed slashing the Medicare reimbursement update to account for improvements in documentation and coding and limiting reimbursement for readmissions.

In addition, the Recovery Audit Contractor program, being rolled out across the country, is aimed at recouping millions of dollars in overpayments to hospitals.

Then, when he outlined his plans for health care reform, President Obama proposed cutting an additional $313 billion in Medicare and Medicaid spending over the next decade.

At the same time, commercial insurers are tightening up on reimbursement and denying claims they used to approve.

## *CMs and eliminating waste*

"The changing health care environment challenges hospitals to become more efficient and eliminate waste in order to continue keeping their doors open," says **Joanna Malcolm**, RN, CCM, BSN, senior consultant for Pershing, Yoakley & Associates in Atlanta.

That's where case managers come in, adds **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY, and health care consultant and partner at Case Management Concepts LLC.

"Case management is all about hospitals getting paid for services they provide, whether it's getting paid for each day the patient is hospitalized or not getting a denial for the care and moving patients through the continuum of care in a timely manner. Case managers definitely have an

effect on their hospital's bottom line," she says. **(For a list of ways case managers affect the bottom line, see chart on p. 115.)**

Case management directors often complain that they can't get additional positions because case management isn't a revenue-generating department, Cesta says.

However, she points out, hospital revenue comes from a bill that represents a combination of services, and case management is definitely one of those services.

"Case management is not any more or any less revenue-generating than any other department, and we do contribute to the hospital's bottom line," Cesta says.

## CMs' impact on revenue, compliance

A hospital's bottom line is not just about money. It's also about quality of care, and that's where case managers can have a huge impact — by eliminating unnecessary admissions and patient days, preventing readmissions, and ensuring that patients receive the evidence-based care mandated by the core measures, Cesta points out.

If hospitals don't pay close attention to the care they are providing to all patients, and not just those with commercial payers, they won't be able to compete in the new health care marketplace, she explains.

"In the past, Medicare was a free ride. Now that CMS has rolled out the Recovery Audit Contractors and other initiatives, case managers need to focus just as much on Medicare as on commercial payers and optimize care for all patients," Cesta says.

In addition to optimizing revenue, case managers can be instrumental in making sure that their hospitals comply with regulatory issues, Cesta points out.

"Hospitals are not in compliance if they don't have a utilization review committee or if they don't use Condition Code 44 correctly or give the Important Message from Medicare properly. The days of being able to slip by are way over," she says.

With the emphasis on reducing length of stay, hospitals need to be fully staffed and provide all services seven days a week instead of being fully operational only five days, Cesta says.

"The next greatest opportunities case managers have to affect their hospital's bottom line is weekend coverage. All the low-hanging fruit is gone, but we still have reimbursement vulnerability with weekend issues," she says.

Most hospital case managers report that they are swamped with work on Monday because few patients go home over the weekend, and they start the week on high capacity.

## 'Break the patterns'

"Hospitals need to look for patterns and do something to break the patterns, such as reaching out to nursing homes to accept patients on Sundays

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and having a dedicated physician to write orders for discharge on the weekend," Cesta says.

It all goes back to staffing and whether the administration supports case management, she adds.

Case management directors have to make a case for the right number of people on their staff and to show management that yes, the work of case management does affect the bottom line, Cesta says.

"If the department isn't staffed properly, it's a challenge to do these things. If the case managers aren't on site on the weekends, they can't do the proactive things that positively impact length of stay and capacity issues. Instead, they're putting out fires all the time," she explains.

One of the most important things that case managers can do is to provide education to the hospital's administrative team and governing board on the role they play, says **Brenda Keeling**, RN, CPHQ, CPUR, of Patient Response, a Milburn, OK, health care consulting firm.

"Case management is defined very differently facility to facility, executive to staff. Often the case manager role expands because 'you're in the chart' in ways that create inefficiencies and duplication of effort. Case managers are very diligent and knowledgeable but when they have too much work, something is going to fall through the cracks," Malcolm adds.

Not only do hospitals need adequate case management staff, they need qualified case managers who are well trained and understand reimbursement issues, Keeling points out.

"Too often, case managers are nurses who may have suffered a back injury or developed carpal tunnel syndrome and are then put in the case management role without the skills or tools to do their job," Keeling says.

"With the emphasis on patient flow and readmissions, case managers must identify what patients will require at home after discharge as early in the stay as possible, and this means performing an initial discharge planning assessment on the day of admission," Cesta adds.

One way to improve throughput is to ensure that all members of the treatment team communicate well with each other, adds **Joyce Evans-Bailey**, RN MBA, consultant with Compirion Healthcare Solutions, a health care consulting firm with headquarters in Madison, WI.

"Working with the doctors for discharge plans during their rounds helps case managers plan the stay of the patient during the 22 hours a day that the doctor isn't at the hospital," she says.

Bailey has developed a course to educate case managers and charge nurses on the role each plays in patient care and to increase communication between the two disciplines.

"The case managers and charge nurses look at patients from two different viewpoints, but they can work together on a common goal and improve patient care," she says. **(For how that process worked at Bay Medical Center in Panama City, FL, see related article on p. 119.)**

Get all the disciplines together and look at barriers to discharge, Bailey suggests.

Start on the unit that has the most admissions from the emergency department because that's where throughput is most critical, she suggests.

"Look at what happened on Day 2 that kept a patient from going home on Day 4 and brainstorm

## How Case Managers Contribute to the Bottom Line

*The Financial Bottom Line*

**Length-of-stay management**
- Coordination of care
- Patient flow
- Identification of avoidable days
- Optimization of hospital days
- Management of long-stay patients
- Timely and appropriate discharge planning

**Other Financial Outcomes**
- Retrospective denial and appeal management
- Participation in clinical documentation improvement efforts
- Management of observation days
- Coordination of Code 44 management
- Product and resource management

**Quality-of-Care Bottom Line**
- Participation in core measures
- Readmission management
- Present-on-admission documentation
- Prevention of inappropriate admissions

**Service Bottom Line**
- Patient satisfaction
- Staff satisfaction
- Physician satisfaction

*Source:* Toni Cesta, RN, PhD, FAAN, Senior Vice President, Operational Efficiency and Capacity Management, Lutheran Medical Center, Brooklyn, NY, and Health Care Consultant and Partner at Case Management Concepts LLC.

on how to overcome the barrier," Bailey suggests.

Make sure that you have basic information that will affect patient discharges, such as a phone number of a family member and what time he or she can transport the patient home, she adds.

"Hospitals often become so technologically advanced that the staff forget that important piece of discharge planning," she says.

If your hospital is tight on beds, look at the process side. If a lot of patients are staying until the early evening hours when their family members get off work, consider setting up an alternative unit for patients who no longer have acute care needs, Bailey suggests.

"If they're medically stable and can go home but don't have transportation, they could be placed in a medical discharge unit until their family can pick them up," she says.

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# ED gatekeepers essential to financial health

*CMs maximize reimbursement*

A robust emergency department case management program is becoming essential as hospitals struggling with capacity and payer sources clamp down on inappropriate admissions, says **Toni Cesta,** RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY.

"Hospitals need case managers in the emergency department to stop inappropriate admissions. There is no value in admitting a patient and exposing him to the hospital environment and not getting paid for it," she says.

Cesta advocates putting case managers and social workers in the emergency department for a minimum of eight to 12 hours a day to review every single admission for medical necessity and admission status. They need to be dedicated to the department full time and not just be on call or float through the ED, Cesta says.

"A few hospitals have case managers in the ED 24-7, but that may not be necessary. I advocate for 16-hour coverage during the week and absolutely on the weekends when so many inappropriate admissions sneak in," she says.

Simply having a case manager review all admissions from the emergency department can have a major effect on the bottom line, adds **Joanna Malcolm**, RN, CCM, BSN, senior consultant for Pershing, Yoakley & Associates in Atlanta.

Many times the case management department simply does not have the staff to place someone full-time in the emergency department, she says.

"But this is a situation where hospitals can't afford not to have a gatekeeper in the emergency department, even if it's just for one shift," Malcolm adds.

An emergency department case manager can ensure that patients who aren't appropriate for inpatient care get treatment in the emergency department and are discharged to home, rather than being admitted, she reports.

"People have had the idea that if you keep patients out of the hospital, the hospital will lose revenue. But if patients are admitted inappropriately, the payers won't pay and the Recovery Audit Contractors are going to take it back," she says.

The problem is compounded by the fact that some hospitals contract for the services of emergency department physicians, and often the contract is based on the expected number of admissions, points out **Brenda Keeling**, RN, CPHQ, CPUR, of Patient Response, a Milburn, OK, health care consulting firm.

"Procedures that once were appropriate admissions are now performed in the outpatient setting. This should result in reduced admissions and an increase in outpatient services, but for some emergency room physicians, the game plan increases admissions if possible," she says.

The hospital is unlikely to be reimbursed if patients are admitted for conditions such as chest pain, medical back pain, and interventional cardiology procedure, Malcolm points out.

"There are many disease processes that can be handled in the emergency department, rather than admitting the patients," she says.

For instance, patients with congestive heart failure may be able to go back home instead of being admitted for several days if they are given

Lasix and oxygen and kept until their condition stabilizes, Malcolm says.

"If hospitals do not have a sufficient census to put a full-time case manager in the emergency department, they should develop a process where a case manager reviews the records prior to a level-of-care determination," Keeling says.

Have someone from your case management staff visit the emergency department every few hours and review the records to make certain that patients meet admission criteria, she says.

An alternative would be to take one case manager out of the floor mix and give him or her the responsibility of reviewing all admissions that come in that day and the night before, Malcolm says.

Direct admissions is another area that needs close scrutiny because it's where a lot of inappropriate admissions slip in, Keeling says.

"Most hospitals don't look at direct admits, but they need to scrutinize them as carefully as other admissions," she adds.

Friday afternoon is a common day for soft admissions, Keeling says.

For instance, a patient may need dialysis on Saturday but the dialysis clinic is closed; so, the patient may be admitted with a vague diagnosis so he can receive his dialysis on Saturday.

Make sure that your case managers do more than just validate that the patient's admission meets acute care criteria, Keeling recommends.

"In the past, case managers could focus on substantiating the DRG, but now they need to make sure there is a level-of-care order and that the chart includes the clinical documentation to substantiate the level of care," she adds. ■

# Extra diagnostic testing can cost hospitals big

*Pay close attention to patients' resource utilization*

Hospitals are losing large amounts of money on extra and inappropriate diagnostic testing and procedures, as well as outpatient procedures performed in the inpatient setting because third-party payers frequently are denying the claims, says **Brenda Keeling**, RN, CPHQ, CPUR, of Patient Response, a Milburn, OK, health care consulting firm.

"Case managers should be on the lookout for unnecessary resource utilization because their hospitals aren't going to get paid for it. If they see something in the chart that might be questionable, they should query the physicians about it," she says.

"Often patients come in with one acute care diagnosis and the physician orders diagnostic testing for other complaints that have no correlation to the acute care condition that prompted the admission," Keeling says.

For instance, a patient may come in with pneumonia and complain of having back pain for six months, so the doctor orders an MRI. The chronic back pain has nothing to do with the acute reason the patient is hospitalized, so the hospital is utilizing expensive resources for which there will be no additional reimbursement, she adds.

MRIs of the extremities or the spine for chronic pain rarely can be justified in the acute care setting unless the patient was recently injured, Keeling says.

Another example would be a patient who comes to the emergency department with a possible gastrointestinal bleed, is hospitalized, and receives an esophagogastroduodenoscopy (EGD).

"If the patient is asymptomatic, has a stable hemoglobin and a stable hematocrit, and isn't throwing up or passing bright-red blood, an inpatient EGD may be questioned by the payers and may not be reimbursed. According to Medicare, once the patient is stable, he or she can be worked up on an outpatient basis," Keeling says.

Other times, doctors will order the same test on subsequent days when the results of the first test are within the normal limits and the patient is asymptomatic, such as ordering a complete blood count several days in a row for patients hospitalized with GI bleeding, Keeling adds.

Case managers should review the charts of all patients daily, regardless of payer source, and make sure that the procedures the doctor orders are necessary for the condition for which the patient is hospitalized, suggests **Joanna Malcolm**, RN, CCM, BSN, senior consultant for Pershing, Yoakley & Associates in Atlanta.

For instance, ask the physician if the colonoscopy or the mammogram is really necessary on an inpatient basis or if the patient could get it as an outpatient.

Make sure your staff stagger their hours so someone will be on duty when the physicians make rounds and can query them in person, Malcolm adds.

Make sure that laboratory tests and X-rays and

the reports in the chart are done in a timely manner, she suggests.

"I'm not suggesting that case managers take over the unit secretary's job, but if they notice something is missing, they should communicate that it needs to be there. Otherwise, when the physician makes rounds, if something isn't in the chart, he or she will likely postpone the discharge until the next day," Malcolm says. ■

# Claims data analysis helps hospital recoup revenue

*Appeals, following underpayments generate income*

By analyzing claims data to assure that the hospital was reimbursed appropriately and aggressively appealing all denials and underpayments of claims, DCH Health System in Tuscaloosa, AL, was able to generate a 1.25% increase in net patient revenue.

The additional revenue comes from appealing denials by commercial insurance companies and Medicare, denials that result from the Medicare Administration Contractor (MAC) audits, as well as following up on underpayments by insurers, says **Brian Pisarsky**, RN, BS, ACM, CPUR, director of case management services at DCH Regional Medical Center and Northport Medical Center.

"Our revenue integrity division of the case management department pays close attention to all of the hospital's claims. If we determine that we were underpaid or not paid, we appeal the case," he adds.

## Creation of revenue integrity division

DCH Health System created the revenue integrity division to look for sources of lost reimbursement in October 2008. The division is staffed by nurses and professionals from the hospital business office and works in the case management department.

"The case management staff in my department were already working closely with business office personnel on denials and appeals. We put them together into one department that combines expertise in claims and billing with expertise in medical necessity issues," Pisarsky explains.

The revenue integrity division is staffed by three revenue integrity nurses and four revenue integrity coordinators who have business office backgrounds.

"The beautiful part for us is the marriage between the financial and the medical. There are claims issues that may not make sense if you don't have a financial background and others that are confusing if you don't have a medical background. Our team talks to each other continually and works very closely to ensure that we are paid appropriately," Pisarsky says.

All of the hospital's contracts with insurers are loaded into the computer system. As reimbursement comes in, the computer system compares the claims the hospital submits and the reimbursement received to the insurance company's contract to ensure that the hospital has been paid appropriately.

If a claim has not been paid appropriately or has been denied, the revenue integrity department either issues a formal appeal or calls the insurance company to find out why the claim wasn't paid.

For instance, if the hospital's contract with an insurer calls for $5,000 in reimbursement for a particular claim and the hospital receives only $4,500, it shows up on the computer analysis.

If the analysis determines that the hospital has been underpaid for a claim, the revenue integrity staff drill down to find the cause and follow up with the appropriate hospital department to get additional information before contacting the insurance company.

The revenue integrity team contacts the utilization review staff to ensure that all of the services the patient received were pre-certified and reviews the record to determine if there were medical necessity issues.

"A portion of the unpaid claims involve medical necessity or pre-certification. As soon as they are identified, someone from the department talks to the insurance company. We talk back and forth on any inappropriate payment and take it to whatever level of appeal we need to in order to get it paid," he says.

If it is a medical necessity issue, a revenue integrity nurse reviews the patient record and contacts his or her counterpart at the insurance company.

"When there is a medical necessity issue, it's more effective to have a nurse talk to another nurse because they can talk about the medical issues as well as the billing issues," Pisarsky says.

*(Continued on page 123)*

# CRITICAL PATH NETWORK™

## Throughput initiatives lower discharge time by two hours

*Improved RN, CM communication is the key*

Through a series of initiatives aimed at increasing patient throughput, Bay Medical Center in Panama City, FL, has lowered its average discharge time by two hours.

Initiatives include case managers and charge nurse rounds in the morning and at the end of the day, discharge areas for patients waiting to go home or to a nursing home but with transportation delays, and a team approach to discharge planning.

But perhaps the most important factor in the success of the initiative is increased communication among members of the treatment team, says **Delilah Dennis**, RN, manager of resource management at the 433-bed regional hospital. **(For details on the discharge areas, see related article on p. 120.)**

"There was a divergence in priorities for case managers and nursing. Case management is focused on the care throughout the stay, throughput, and discharge while nursing's focus is clinical bedside care," she says.

The nursing units tried convening a team meeting twice a week in which nurses and case managers could sit down and talk. It worked well in some units, but there was inconsistent commitment in other units, Dennis reports.

The hospital contracted with Compirion Healthcare Solutions, a consulting firm specializing in process improvement, to help improve communications between the two disciplines with a goal of improving patient care and patient throughput.

"We instituted a lunch-and-learn series to teach each discipline about the other's role and to get them started talking to each other," says **Joyce Evans-Bailey**, RN, MBA, who developed a six-week course to teach charge nurses and case managers about the role each play in the hospital.

"The charge nurses didn't understand DRGs, avoidable days, reimbursement issues, or why the hospital is trying to tighten its belt. They needed to see the whole picture and understand that when a person doesn't meet continued stay criteria, he has to go home. Now they know that we are looking at what is best for the patient as well as the hospital's bottom line. It's helped us build a team that works together on patient care issues," Dennis adds.

Following the educational sessions, the hospital instituted 30-minute case manager and charge nurse rounds on every unit during which they discuss all the patients on the unit, who might be ready for discharge, and what has to be done before the discharge can occur.

"Having the case manager sit down with the charge nurse on each unit has helped us get rid of walls and communicate better. They work together and discuss how to speed up the discharge process, and as a result, our patient throughput is improving and the length of stay is dropping," Dennis says.

The process started out on the medical unit, which has many very sick patients, many of whom have long lengths of stay, and was rolled out through the entire hospital, Dennis says.

"At the morning meetings, we talk about who is going home that day, what tests or procedures they need, which patient needs orders for post-acute care, and any issues that might delay the discharge. Now when a patient needs orders for a nursing home or home health referral, the charge nurses help the case manager locate the doctor

and get the orders. They help talk to the family to get them ready for the discharge. We're all working toward the same goal," Dennis says.

Everybody on the team works together to lower the discharge time of day, she says.

For instance, in many cases, the family members come to see the patient after 5 p.m., after the case managers have left for the day. Now, the nursing staff, which works a 7 a.m. to 7 p.m. shift, alerts the family that the patient will be ready to go home the next day and that they should make arrangements to pick them up.

"The constant communication helps ensure that everybody is on the same page. Everybody knows this is our plan and we can start getting the patient ready to go home. It alerts the case managers to give patients the Important Message from Medicare and alerts the nurses of tests or procedures that are pending," Dennis explains.

The charge nurses and the case managers meet again at 1:30 before the afternoon bed board meeting to look at discharges planned for that day and those anticipated for the next day.

"They look at who was supposed to be discharged but hasn't gone home and what the holdup is. They discuss the patients who are scheduled for discharge the next day so the nurses can start the paperwork and alert the family members as they come in to visit after work," Dennis says.

The charge nurses take the information to the bed board meeting so plans can be made for the next day.

The team meets again at the end of the case management shift to discuss what has to happen overnight so the patient can go home the next day.

"These meetings help alert the nurses to be on the lookout for the test results or X-rays. The units get so busy that they may forget something is pending, like holding a patient NPO for a test so that when the results are in, he can be discharged the next day," Dennis says. ■

# Special discharge area frees up beds

*Use of unit improves throughput, ends ED backups*

Faced with a high census and backups in the emergency department, Bay Medical Center in Panama City, FL, created two discharge areas where patients who were waiting for transportation to home or a nursing home could wait, freeing up much-needed beds on the units.

During high census times when the hospital is full, patients who are being discharged to a nursing home are transported to a special discharge unit, created in what used to be the hospital's emergency department.

Patients who are appropriate for the unit don't need acute care but do still need some care, such as IV antibiotics or help going to the bathroom.

The seven-bed unit is staffed by emergency department personnel, usually an LPN. It is equipped with hospital beds, bedside commodes, and doors that shut, allowing the nurses to change the patients' dressing, administer medications, and take care of other patient needs.

"Waiting times for transportation to a nursing home can be several hours or longer. There are only two nonemergent medical transport companies in our area. Two acute care hospitals, a rehab hospital, and Medicaid transportation programs are all in competition for their services. If one company is on a long-distance run, waiting times are very long," says **Delilah Dennis**, RN, manager of resource management.

The hospital also uses the discharge unit for isolation patients, giving housekeeping a head start on cleaning and disinfecting the rooms.

The case managers on the unit are responsible for transferring appropriate patients to the discharge unit. They are accountable for making sure that a bed is available in the nursing home, arranging transportation, and helping transport the patient to the unit.

"Some days, the unit isn't full, but during high census time, it helps free up beds," she says.

Patients who are well enough to sit in a chair and walk to the bathroom may wait for transportation in the ambulatory discharge lounge, located in the central admissions area near the hospital's valet parking lot.

The lounge has a private bathroom and is furnished with a telephone and a television set. It's staffed by transporters who sit at a desk and log patients in. Patients who stay in the lounge through mealtime receive their meals in the area.

"Sometimes patients are ready to go home early in the day but their family members can't pick them up until later. This frees up a bed for incoming patients and gives the discharge patients an area in which to wait," Dennis says.

Family members love the location near the valet parking lot because they can drive up and

pick up their loved ones, Dennis says.

"Our hospital is 50 years old and it's landlocked. Parking is a nightmare, and families spent a lot of time circling the parking lot and often had to park a long way away when they picked up the patients," she says.

*(For more information, contact: **Delilah Dennis**, RN, Manager of Resource Management, Bay Medical Center, e-mail: ddennis@baymedical.org.)* ■

# Patient-, family-centered care helps decrease LOS

*Information sharing, collaboration are key factors*

By involving patients and family members in the treatment plan and discharge process before they are admitted to the hospital for treatment, the staff at Moffitt Cancer Center in Tampa, FL, within a five-month period of time decreased length of stay by almost two days and achieved a 7% increase in the number of admissions involving hematology patients.

On the medical oncology team, patient days were increased by almost 50%, a major improvement in patient throughput.

The facility's emphasis on providing patient- and family-centered care is a major factor in the improved patient throughput, says **Linda Pearson Hodges**, RN, MBA, CCM, ACM, CPHQ, manager of the case management department.

The hospital's 162-bed inpatient unit is at capacity all the time, with patients waiting at home to be called in for treatment, she adds.

The four cornerstones of patient- and family-centered care are: dignity and respect, information sharing, collaboration, and participation.

"We are working to incorporate those four components in every process we implement. We know that if we have this in place, we can improve clinical outcomes and patient satisfaction and increase throughput at the same time," Hodges explains.

As a National Cancer Institute Comprehensive Cancer Center, Moffitt treats more than 7,200 patients and records more than 252,000 outpatient visits a year. The hospital's blood and marrow transplant program is the largest in the Southeast.

"By collaborating and communicating with everybody involved, patient access, throughput, and discharge are so much smoother. It all boils down to having everybody on the same page, and that includes the treatment team, the patient, and the family," Hodges reports.

The case managers facilitate a lot of that communication and collaboration by educating the patients about the conversations they need to have with their physicians. Encouraging dialogue between the treatment team and the patients and family member is a must, she says.

"One of the biggest roles case management and social work have in this process is to push for rounds to occur with the patient, family members, physicians, social workers, case managers, and other appropriate members of the team. This allows the patients to know our individual roles, to know who to ask questions, and to understand that we are all talking about the same thing," Hodges says.

On the bone marrow transplant unit, the entire treatment team — physician, nurse, case manager, and social worker — conducts rounds in the patient room, talking to the patients and family members about their condition and getting their input on the next steps in treatment.

This ensures that everybody on the team and the patient and family are fully informed about what is going home and ensures that patients and family members don't have to track down several different members of the team to get questions answered.

"It's not really any different from what we should have been doing all along. In the health care arena, we have a tendency to decide what is best for the patients and to put patient involvement on the back burner. Patient participation is essential for a successful treatment plan and discharge," Hodges says.

In the bone marrow transplant program, all patients have a consultation with a social worker and a case manager before treatment begins. Then the entire treatment team meets to discuss the patient's treatment plan, including whether the patient's psychosocial needs and coordination of care needs are met.

"We have tried to implement a continual assessment of a patient's needs, including psychosocial needs as well as resource utilization needs," Hodges explains.

Participation is one of the key elements to making the patient- and family-centered care process work, she says.

"In oncology particularly, we tend to think we know what is best for the patient, but we cannot have physicians and the treatment team acting in a vacuum. The patient needs to be involved. If a

patient is not participating in treatment planning and is not fully informed about his options, he may not make good decisions," Hodges says.

When a patient is receiving oncology care, it often takes more than one discussion with the family, physicians, and support personnel for the patient to feel comfortable making a decision, she reports.

Hodges tells of a patient who was set up for surgery but called to say he was having second thoughts. She arranged for the physician to call the patient and go over every option again. The patient ended up choosing radiation treatment.

"The first time patients come to the facility, they are stressed and fearful. The whole diagnosis and treatment process is overwhelming. We help them become informed so they can make better decisions," she says.

In the past, the physician would recommend surgery and the patient would just say OK, Hodges adds.

"Now we let them know that the treatment is their decision. The case managers and the social workers offer them the support and information they need, and we ask them to participate in the choices. They can go back and discuss the options further with the physicians if they want," Hodges says.

Patient- and family-centered care has had a huge impact on ensuring that patients are preparing to go home on the day they are admitted, she says.

"We know as case managers that we can tell patients in the hospital that they're ready to go home, but if the patient and family aren't ready to go, they don't go. Even the Important Message from Medicare tells them that if they don't feel they are ready, they don't have to go," Hodges points out.

By including patients and family members in the treatment plan and keeping them informed throughout their stay, they're prepared to go home when they're clinically ready to be discharged, she says.

In the past, case managers at Moffitt started discharge planning on the day of admission. Now the team starts looking at a patient's discharge needs in the clinic setting, before he or she is admitted to the hospital.

"We are looking aggressively at the patient's discharge needs before admission and making sure that the patients and family members are ready for discharge," she says.

For instance, since hematology patients have complex discharge planning needs, the case manager meets with them individually on admission or even in the clinic setting and discusses the treatment plans.

"We help them understand how they can be involved in the treatment decisions, look at caregiver impact, and determine what we can do at our facility vs. what can be done on the local level, and incorporate all of that into the inpatient experience. When there is better communication between the family, patient, and providers, it expedites patient throughput," she says.

For instance, hematology patients usually are discharged with multiple IV antibiotics and must either go home with home health services, receive them as an outpatient in their community or come back to Moffitt for infusion, a drive of several hours for many patients.

"The patient has a choice, and we respect that. We try to arrange what is best for the patient, but we don't know what their choices are until we sit down with the patient and family and discuss it," Hodges says.

If the case managers know in advance what the patients' preferences are, they can arrange for an oncologist in their home town to give them their medications. The case managers can collaborate with social workers in assisting patients in finding accommodations in Tampa if they choose to stay close for their outpatient treatment. That way, there are no delays in discharge and patients know what is going to happen when they go home, she says.

The goal of Moffitt's patient and family care initiative is to involve patients in key decision-making processes throughout the organization as well as making sure that patients undergoing treatment are informed about and comfortable with their treatment plan, Hodges says.

The hospital has created a patient advisory board to give the staff input in areas of operation. Patients sit in on planning committees and performance excellence committees throughout the hospital.

The hospital is looking at health care delivery from a patient and family member standpoint, Hodges says.

For instance, a team of patients has advised on ways to improve patient access to the facility. The hospital has met with a group of patients undergoing outpatient chemotherapy infusion to get their input on how staff can better prepare the patients for what to expect during treatment.

*(For more information, contact:* ***Linda Pearson Hodges****, RN, MBA, CCM, ACM, CPHQ, Manager, Case Management Department, Moffitt Cancer Center; e-mail: Linda.Hodges@moffitt.org.)* ■

(Continued from page 118)

When insurance company contracts are up for renewal, the hospital's contracting staff use the data to negotiate contracts. For instance, if the contracting staff have data that show that the insurer consistently underpaid claims, it may be able to negotiate a higher payment amount or a change in the contract provisions.

Pisarsky uses the data to educate his staff when analysis shows that there were problems with documentation or utilization management.

"If we identify patterns in the denials that are due to our practices, we develop quality improvement and process improvement initiatives to correct the problem," he says.

*(For more information, contact:* ***Brian Pisarsky****, RN, BS, ACM, CPUR, Director of Case Management Services, DCH Regional Medical Center and Northport Medical Center, e-mail: bpisarsky@DCHSYSTEM.com.)* ■

# ED CM facilitates appropriate care level

*Program aims to save resources for hospital, patients*

As emergency department case manager, **Janeice Garrison**, RN, MSN, BC, sees herself as the "point guard" for the hospital in a large, mostly rural area where the population is growing by an average of 22.4% a year and the percentage of uninsured, undocumented, and homeless patients is increasing.

"For every patient I can get into an appropriate level of care, I can save resources for the hospital, the community, and the patient," says Garrison, emergency department case manager at Winchester Medical Center, a 411-bed regional medical center with a Level II trauma center. The Virginia facility draws patients from a three-state area.

In 2008, Winchester Medical Center experienced 66,591 emergency department visits. Of these, 75% were discharged to the community and 25% were admitted to the hospital.

The position of emergency department case manager was created in 2004 to ensure that patients who are not admitted to the hospital receive follow-up care and help them navigate the health care system after discharge from the ED.

The hospital's unit-based case management staff rotate through the emergency department to handle medical necessity and admission status issues.

"I take care of the 75% of patients who aren't admitted but who need help with navigating the health care system," Garrison reports.

Garrison is responsible for calling patients after discharge from the emergency department to assist with scheduling outpatient appointments, calling patients with laboratory results and helping them get follow-up appointments, facilitating admissions for alternative levels of care for patients who don't meet acute care criteria, and addressing recidivism rates in the emergency department.

She also collaborates with the hospital's social workers and utilization review staff and assists with transfers or referrals to community resources for patients who don't meet acute care admission criteria.

Garrison collaborates with the case manager on the unit to ensure that patient care is coordinated.

"I try to be the link between inpatient and outpatient care. When a patient is referred to me, I look to see what the in-house case manager has done and work from that. The reverse is true; if I have worked with a patient being admitted, I give a heads up to the case manager and the social worker on the floor," she says.

Like other hospitals, Winchester Medical Center is challenged with capacity issues, long waits in the emergency department, denials for care, and a growing segment of uninsured patients, Garrison reports.

"It's well documented across the country that there are an increasing number of patients who don't have a primary care physician, who don't have insurance, and who have poor adherence to their medication regimen and treatment plan. Many use the emergency room for primary care or don't receive the follow-up care they need. I concentrate on getting patients to the appropriate level of care and helping them access community resources," she explains.

Garrison receives referrals from the emergency department staff and from the hospital's patient advocates, who cover the emergency department 24 hours a day and are on the lookout for patients who need extra assistance.

She has developed a simple referral form with spaces for the name of the person making the referral, the reason for the referral, and the patient label, which gives Garrison the information she needs to access the patient's medical record.

Much of Garrison's communication with patients is via telephone but whenever possible, she sees them in person.

A lot of patients from rural areas come to the emergency department at Winchester because they don't know where to find resources near their home, or they don't know how to apply for them, Garrison says.

When patients appear to use the emergency department as a primary care provider, she tries to get them to see a primary care physician. When they can't afford care, she helps them apply for the hospital's financial assistance program or other community resources.

"I am most successful with patients who want to do something for themselves. There are those patients, however, that I simply cannot help because they just don't want any assistance," Garrison says.

Many of the patients and family members are very appreciative of getting the care and assistance they need, she says.

Garrison contacts all the family practices in the region that Winchester Medical Center services on a quarterly basis and finds out which are taking new patients and what restrictions they have on taking new patients. For instance, many of them will restrict the number of Medicaid or Medicare patients they see.

"We have practices that don't take Medicare or Medicaid patients and those which charge uninsured patients on a sliding scale based on income, but they often have to limit the number of these patients they can see every month," she says.

She keeps up with which practices use physician extenders and offers patients an appointment with a nurse practitioner or a physician assistant if they can't get a physician appointment.

She maintains a relationship with area dental, clinical, and mental health clinics as possible resources for patients who present to the emergency department.

"Basically, I try to keep a handle on what is out there so I can help patients get treatment at the appropriate level of care. For a lot of patients, my main job is being an educator," she says.

For instance, many patients who come to the emergency department with back pain insist on a referral to a neurosurgeon instead of a referral back to their primary care physician.

Often when a doctor orders an MRI and the hospital tries to get preauthorization from the insurer, the procedure is denied if the patient hasn't had 30 days of outpatient treatment.

"This is when the patient is directed back to his primary care physician for continued support and interventions prior to such an expensive test. If a patient needs a neurosurgeon or specialty appointment, I review the case with him and offer referral assistance. These actions are under guidance of the emergency department physician's group," she says.

When patients from the emergency department get prescriptions filled and pharmacists have questions, they contact Garrison.

"Many times, the doctor prescribes a medication that isn't on the patient's insurance company formulary. I go back to the doctors and ask if they could prescribe something else," she says.

The pharmacies like the arrangement because they don't have to wait hours for a physician to return phone calls and the physicians are happy to be freed up from calls from pharmacists, she says.

*[For more information, contact:* ***Janeice Garrison,*** *RN, MSN, BC, ED Case Manager, Winchester Medical Center, e-mail: jgarriso@valleyhealthlink.com; Additional information is available through the AHC Media's webinar series. Learn more at www.hcmconference.com or call (800) 688-2421.]* ■

ACCESS MANAGEMENT
QUARTERLY

# Identify uncollectible accounts early

*Also examine your process for self-pay patients*

Is a patient's account uncollectible? Is your self-pay patient eligible for financial assistance? Both of those scenarios are becoming more common due to the recession — and if the answer to either of those questions is "yes," you should know sooner rather than later.

Uncollectible accounts should be written off promptly so they won't adversely affect days in accounts receivable (A/R); but whether an account is uncollectible is "very difficult to determine promptly," says **Adam Anolik**, director of financial operations at Strong Memorial Hospital

in Rochester, NY. Also, it may not be readily apparent that your self-pay patient is eligible for charity care.

These two processes are extremely important to patient access departments, since otherwise, the accounts will be considered "bad debt." Here are three strategies used by Strong Memorial's patient access department to quickly identify which accounts are eligible for financial assistance and which should be written off:

• **The department focuses on self-pay balances of more than $10,000.**

Anolik says his department is seeing more self-pay accounts. He says this is partially due to the fact that many patients with employer-sponsored health insurance have plans that carry high deductibles and coinsurance. "We are receiving more calls from patients questioning charges, balances, asking for estimates on services, and inquiring about our charity care program," he reports.

"We run reports of accounts with self-pay balances over $10,000 each month," says Anolik. "These are reviewed in a group setting to determine what we expect from a collectibility standpoint."

One example would be a large account where the patient has applied for Medicaid but has not yet been approved. "We typically will review those types of cases with the financial counseling department and determine what follow-up, if any, is needed," he explains.

Another example would be an account for a patient who was uncovered at the time of the service but was subsequently approved for Medicaid or some other type of insurance. "In those cases, we might have enough financial information about the patient to determine that the prior account should be treated as charity care even if the patient had not applied for financial assistance," says Anolik.

For instance, one patient had a $40,000 balance due for a self-pay visit and had applied for Medicaid with the hospital's internal case management team. In this case, the patient was denied Medicaid as the necessary documentation was not provided.

"In this case, our self-pay collector would review the completed Medicaid application, check to see if the patient has any type of Medicaid coverage currently, and attempt to contact the patient," says Anolik.

If the Medicaid application shows that the patient does not have resources above the hospital's financial assistance guidelines and the services are too late to obtain Medicaid coverage, the balance would be considered presumptive eligible for

## CNE *questions*

5. How much does President Obama propose cutting out of the Medicare and Medicaid budget in the next 10 years?
A. $52 billion
B. $210 billion
C. $230 billion
D. $313 billion

6. According to Toni Cesta, RN, PhD, FAAN, what is the minimum number of hours the case managers should cover the emergency department?
A. Eight to 12
B. Twelve to 16
C. Sixteen to 18
D. Twenty to 24

7. By analyzing claims and reimbursement data and vigorously appeals denials or underpayments, DCH Health System has increased its net patient revenue by how much?
A. 1%
B. 2%
C. 1.25%
D. 2.25%

8. Winchester Medical Center created the position of ED case manager in 2004.
A. True
B. False

**Answer key: 5. D; 6. A; 7. C; 8. A.**

## CNE instructions

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

financial assistance. If a patient has current Medicaid coverage, he or she would be presumptively eligible for financial assistance.

"If we are unable to make any type of determination as to income/resources and the patient is unresponsive to our attempts to contact them, the account would be considered uncollectible," says Anolik. The department's collection agencies also are well versed in the hospital's financial assistance program and will forward financial assistance applications to patients.

**• Selected outpatient accounts are outsourced to an external vendor.**

Some insurance accounts aged 60 or 90 days from the date of service that are not yet paid are sent to an external vendor. "We receive routine reports back from the vendor that show success as defined by cash collections," says Anolik. "In terms of metrics, we tend to look at the percentage of outpatient accounts over 90 days to measure the effectiveness of this. We are running between 25% and 35% in this measure, with a goal of under 30%."

**• The department has implemented a new billing system.**

"There certainly is more functionality in our newer system that enables us to better estimate the ultimate amount we will be paid for the services provided," reports Anolik. "There are also more reporting capabilities that assist us in working accounts that have been denied, or where payment has been delayed by the insurance companies through the use of 'worklists' that our staff have access to."

## Is the account uncollectible?

"Accounts are only written off when they are determined to be uncollectible," says Anolik. Typically, two statements are sent out to patients seeking payment up to a set dollar threshold. After that point, an "Early Out" vendor is used, which continues to attempt to collect the debt prior to it going to a collection agency.

"In total, this process can take six months or longer, depending on the nature of the case," says Anolik.

If a patient has elected to apply for Medicaid or charity care, the balance is often not written off as uncollectible until a decision on eligibility for Medicaid or charity care is determined.

"For those visits not being sent to our 'Early Out' vendor, we review internally and make recommendations for charity care, sending to our internal attorney or to our outside collection agencies," Anolik reports.

In the past year, the hospital's web site was updated to include information on its charity care program. "We also plan to begin accepting payments from patients on-line in the future, although that will be primarily after the services are provided and not up front," he says.

**At UCLA Hospital System, self-pay collection representatives have a minimum daily production standard of 40 accounts per day. The quality standard is a minimum of 90% of accounts undergoing quality assurance review.**

## Are self-pay accounts eligible?

At Strong, a monthly report is run to identify very large self-pay accounts. These are reviewed for charity care eligibility and whether further follow-up is needed before a determination of uncollectability is made.

"There is also a self-pay team that meets monthly to review large-dollar inpatient accounts and make possible recommendations for collection," says Anolik. "Improvements to the self-pay collection process are discussed in this forum."

At University of California, Los Angeles (UCLA) Hospital System, self-pay collection representatives have a minimum daily production standard of 40 accounts per day. The quality standard is a minimum of 90% of accounts undergoing quality assurance review.

"It's important for these accounts to be worked effectively to assure timely receipt of payment for services rendered, to provide accurate information

to the patient, to reduce bad debt, to reduce aged receivables, and to reduce A/R days," says **Bernadette Lodge-Lemon**, director of revenue cycle.

Lodge-Lemon notes that her department must comply with federal and state regulations regarding bad-debt assignments. "California Assembly Bill 774 regulates the process and manner in which patients may be assigned to a collection agency," she explains.

First, the patient must be provided with notice that if they do not have health insurance coverage they may be eligible for Medi-Cal, Healthy Families, California Children's Services, or charity care. If patients do not respond, they must be provided with a final notice and advised that nonprofit credit counseling may be available.

"We are required to assist patients in applying for possible governmental program coverage, offer no-interest payment plans and/or discounts for prompt payment," says Lodge-Lemon. After meeting these requirements, the account is eligible to be assigned to bad debt collection, which constitutes a write-off as uncollectible.

"Accounts qualify daily for this process. We employ dedicated self-pay collection representatives reporting to a designated supervisor and manager to actively monitor these accounts in efforts to assure that they are handled expeditiously," she explains.

If the patient's responsibility is identified up front by patient access staff and has not been collected, collection representatives have systematic work drivers that queue those cases by dollar value, date of service, broken payment promises, and insufficient funds checks.

"The collection representatives have daily, weekly, and monthly productivity and quality standards that are closely monitored to assure that the accounts are being worked timely and effectively," says Lodge-Lemon.

### Technology determines eligibility

Strong Memorial's patient access department uses a variety of real-time applications to determine Medicare, Medicaid, and commercial insurance eligibility.

"In terms of financial assistance for charity care, the only upfront verification occurs when a patient has previously applied for and been approved for charity care prior to services being rendered or has existing services where they have been approved previously," says Anolik.

Also, Strong's case management team will review for Medicaid or charity care eligibility while the patient is receiving inpatient care.

### Patient access staff use several systems

Patient access staff at UCLA use several automated eligibility systems, including Health Plan web sites, which offer batch eligibility, the Medicare direct data entry system, and point-of-service eligibility devices throughout the patient access departments for individual eligibility verification.

Initial training was provided by the vendors, and follow-up training was conducted by the managers and supervisors. According to Lodge-Lemon, the systems are fairly intuitive and easy to learn.

"The benefits include not having to place calls and navigate through myriad telephone prompts," says Lodge-Lemon. "There are flexibility advantages in verifying eligibility 24 hours

## 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

- Strategies for preventing readmissions
- How to put technology to work for you
- Tips on increasing patient throughput
- The importance of having CMs in the emergency department

per day, seven days a week for most payers, and realized cost benefits through automation rather than manual resources."

*[For more information, contact:* ***Adam Anolik****, Director, Financial Operations, Strong Memorial Hospital, Rochester NY. E-mail: Adam_Anolik@urmc.rochester.edu;* ***Bernadette Lodge-Lemon****, Director, Revenue Cycle, University of California, Los Angeles Hospital System. Phone: (310) 794-8299. E-mail: BLemon@mednet.ucla.edu.]* ■



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