# HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

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# Case management role is likely to expand under health care reform

*Efficiency, quality of care, smooth transitions will gain in importance*

As health care reform rolls out, hospitals will be under more pressure to deliver care faster and more efficiently with better outcomes, coordinating care while patients are still in the hospital, and ensuring a smooth transition to the next level of care. And that's where case managers can make a difference, experts say.

"Hospitals are going to have to be more efficient in the way they deliver care and at the same time improve the quality of care. As they struggle with these challenges, case management should become an important part of the process. Case managers can help optimize care process outcomes, including financial outcomes, quality of care, and the patient experience," says **Cary D. Gutbezahl**, MD, president of Compass Clinical Consulting, with headquarters in Cincinnati.

With health care reform and the influx of newly insured patients who seek care, it will be more important than ever for case managers to manage the care process so that patients receive the right level of care at the right time, adds **James R. Proctor**, a director with KPMG LLP, the U.S. audit, tax, and advisory firm.

Proctor envisions a more important role for case managers as the provisions of the Patient Protection and Affordable Care Act go into effect over the next few years.

"Case managers must make sure their hospitals deliver efficient care at the right level and in a manner that produces good outcomes. The earlier case managers become involved with patient care coordination and shepherd them through the care process, the better the quality of care and outcomes will become," he says.

Because health care reform aims to improve access to care, reduce costs, and improve quality and outcomes, case management is right on the frontline, adds **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president of Mullahy & Associates LLC, a Huntington, NY, case management consult-


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ing firm.

"If case managers felt like they have been in the line of fire with lack of resources and having to do more with less, just wait until health care reform starts unfolding," she adds.

The health care reform legislation passed by Congress in March simply accelerates the transformation that already has been taking place in the health care industry, Proctor points out.

"The key drivers of health care reform are about decreasing costs, improving access, and improving quality. That hasn't changed. The priorities have just changed in some respects," he says.

Under health care reform, the Centers for Medicare & Medicaid Services (CMS) and commercial payers will continue to tighten up reimbursement, especially for hospital-acquired conditions and readmissions within 30 days, Gutbezahl predicts.

Health care reform also will place additional pressures on commercial payers, which is likely to make them less flexible and more likely to deny payment for care unless previously authorized, Proctor adds.

Hospitals already are experiencing financial pressure, and they will face more as health care reform kicks in, Proctor adds.

Because financial reimbursement is going to change, there will be more pressure to get patients out of the hospital quickly and to make sure that they have a discharge plan that helps them avoid being readmitted, Mullahy says.

Many in health care predict that when the number of people with insurance coverage increases, physician offices and hospitals will be flooded with an overabundance of new patients.

Hospitals can expect an influx of patients in their emergency departments, due in part to the shortage of primary care physicians, Gutbezahl says.

"With more people insured, the demand for services will go up and the supply of outpatient providers will be limited. People who can't get an appointment with a physician will go to the doctor's office of last resort — the emergency department," he says.

In addition, many people who haven't had insurance don't have a lot of experience in using the health care system, and they may think that the emergency department is where they go for treatment, Gutbezahl says.

With so many emergency departments already operating at capacity today, even the slightest uptick will be problematic, Proctor adds.

"The continued trends in utilization are not sustainable if a flood of newly insured [patients] enter the marketplace. Hospitals will have to deliver care faster and better, both from an operational and a financial standpoint," Proctor says.

Hospitals must be prepared to expedite care for patients who present to the emergency department,

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regardless of whether they are admitted as inpatients, receive observation services, or are referred to other resources in the community, Gutbezahl says.

"I can see a greater role for case managers in the emergency department. Hospitals are going to have to do a better job of gatekeeping and triaging patients by applying admission criteria immediately to determine if [patients] meet medical necessity for an inpatient admission, rather than doing so after the fact," he says.

Hospitals can't afford to admit patients and then change their admission status after the case manager sees them the next day, Gutbezahl adds. They are going to need to assess patients quickly to determine if they qualify for inpatient admission or need observation services before they are placed in a bed, he says.

Moving patients through the system as quickly and safely as possible will be more important than ever, he adds.

Once patients are admitted, it is important for case managers to work closely with social workers to find community services early in the hospital stay for patients who will need them after discharge, he adds.

"Case managers can have a huge impact on length of stay by lining up the community resources people need after discharge," Gutbezahl says.

With the volume of patients increasing, the pressure on case managers is likely to increase, Proctor says.

This means that hospitals will need to make the highest and best use of the case managers' professional skills and training and offload some of the tasks that don't require a nursing degree, he adds.

In many hospitals, the case management role is not really concerned with managing the care of the patients, and that has to change, Proctor says.

"In many hospitals, the case managers are required to focus largely on retroactive utilization management and retrospective review versus assisting patients in navigating the oftentimes complex health care delivery system. I see opportunities to give case managers enhanced responsibilities in many hospitals," he says.

For instance, at many hospitals, case managers spend several hours a day on the telephone with managed care companies. The same tasks could be handled by a paraprofessional unless a clinician-to-clinician discussion is necessary, he adds.

"Tasks like documentation and assembling data for the Recovery Audit Contractors are an important function for hospitals, but putting case managers in charge of these tasks is not making the best use of their time. They may know what is needed to do the job. They can sort through the medical records, but that's not managing patient care," Mullahy points out.

The more tasks that case managers are responsible for, the fewer patients they can manage, Gutbezahl points out.

He recommends that case managers be limited to the case management role, rather than taking on documentation and other tasks that require a lot of time.

"When case managers are responsible for documentation, they spend more time on chart review and tracking down physicians to improve documentation. None of this relates to getting a patient treated and discharged in a timely manner. It creates a distraction and prevents case managers from fulfilling their roles," he says.

Make sure your hospital takes advantage of the case managers' clinical expertise and that they spend their time efficiently, allowing them to get more involved with patient care earlier in the patient stay, Proctor advises.

Educate hospital administration that it's impossible to manage the care of complex patients and take on all the other tasks case managers often are given "since they're already in the chart," Mullahy says.

"Case managers need to advocate for themselves and help the administration understand that they can't wear all these hats and do an effective job," she adds.

Often physicians don't see case managers as clinicians who work with patients. Instead, case managers are perceived as documentation specialists, she adds.

"Handling paperwork is not why we went to school. I don't think you need highly trained, compassionate people to perform documentation assurance. This can be done by coding specialists or people with medical terminology expertise," Mullahy says.

Advocate for administrative support or case management assistants who can take over some of the clerical duties such as paperwork and telephoning, Mullahy says.

"Nurses should be handling activities that only a nurse can do. Physicians often have physician assistants to take over some of their work. Case managers need a similar type of assistant," she says.

To be effective, case managers should see patients with a medical admission every day to evaluate them for medical necessity and to determine what they need to move quickly and safely through the continuum, Gutbezahl says.

"Many hospitals have protocols for patients on the surgical unit. With a medical admission, the direction of care is less certain, and someone needs to facilitate inpatient care every day. It requires discipline and a commitment," he says.

Gutbezahl recommends that case managers on medical-surgical units should have limited focus and a caseload of 20 to 25 patients in order to maximize their efforts at care coordination and patient throughput.

Case management directors should concentrate on their role to drive the care management process and make sure it works effectively and efficiency, Gutbezahl advises.

"This means that case management managers can't spend all their time going to meetings. They should pick their meetings carefully and limit them to those where they can have an effect," he says.

For instance, a case management director should attend a throughput meeting but possibly skip a general standing meeting for infection control.

As their role in care coordination increases, case managers are going to need more resources to handle the extra responsibilities, but they may be challenged to prove it to the hospital management, Mullahy says.

"Perception is everything. If an organization doesn't perceive case management as having value, it won't give them the resources they need," she says.

To get more staff, which will be needed to move the influx of patients in and out of the hospital, case managers must be able to demonstrate the value of what they are doing, Gutbezahl says.

"It's all about metrics. If case management departments don't have good metrics, they're an expense to the hospital. When case managers can demonstrate how much money their efforts are saving, the hospital administration isn't interested in cutting their program," he says.

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# Report patient safety lapses in your hospital

*CMs can help eliminate careless behavior*

Hospital case managers are involved with patients from admission through the entire episode of care and discharge, which puts them in a position to spot patient safety issues and work on ways to prevent them, says **John Banja**, PhD, professor of rehabilitation medicine, medical ethicist at Emory University's Center for Ethics and director of the Section on Ethics in Research at Emory's Atlanta Clinical and Translational Science Institute.

"Since case managers observe patients during the entire hospital stay, patient safety has got to be an integral item on the case manager's radar screen. When lapses of safety occur, case managers are among the most likely people to pick up on it," he says.

As the Centers for Medicare & Medicaid Services (CMS) moves toward denying reimbursement for hospital-acquired conditions that can be prevented, with commercial payers likely to follow suit, it's more important than ever to eliminate careless behavior by the staff who are providing care, Banja points out.

The first rule of health care ethics is to do no harm, he says.

"If we have elements in our system that expose patients to an unnecessary level of harm and we're not doing anything about it, we are breaching our ethical obligations," he says.

Hospitals are very complex organizations, and if there is just one glitch in an entire process, it could result in a patient safety issue, Banja says.

For instance, dozens of people are involved in the processes that take place between the time a physician orders a medication and the time a patient receives it.

If a patient doesn't get his or her medication on time or gets the wrong medication or dose, it could be that the doctor's handwriting was illegible, that the pharmacy issued the wrong medication or dose, that the nurse failed to administer it on time, or other scenarios.

"When the glitches occur, nothing bad happens the majority of the time, but that can seduce us into thinking the system is safe enough. Then out of the blue, a patient gets the wrong medicine and a catastrophe occurs," he says.

The health care system has a tendency to tolerate a lot of imperfections, as well as tolerating people — especially physicians — who are known to be careless, Banja says.

In addition, clinicians often have to treat patients when information is missing from the medical records. Equipment may not work properly or a clinician routinely fails to wash his or her hands between patients.

"These kinds of things happen, and sometimes we don't take steps to correct them as aggressively as we should," he says.

Most nurses on the unit know which nurses are pulling their weight and which ones tend to take short cuts in patient care, he adds.

"Health professionals, especially nurses, understand that they work within an imperfect system, and they're always putting Band-Aids on those imperfections. The problem is that while nurses are unsung heroes and heroines who can get the job done under extreme circumstances, they are not especially good at coming up with long-term fixes," he says.

Most hospitals are very good at short-term fixes for system problems that occur, but they fall short when it comes to making permanent changes in hospital processes to eliminate errors, Banja says.

For instance, when a case management director reviews data, he or she may notice a spike in urinary tract infections or central line infections. This could be the impetus for a quality improvement project, first to determine the cause of the increased infections and then to take steps to correct the problem, he says.

"Most patient safety issues do not tend to be dramatic things like wrong-site surgery. They generally tend to be the more mundane things that people overlook and omit doing," he says.

Look for patterns, Banja says.

"People make errors. It's when there is a pattern of these errors happening that you know something is systemically wrong," he says.

For instance, one observational study of physicians showed that more than a third miss one of the five basic steps in putting in a central line, Banja says.

"Health care providers need to develop checklists like airline pilots have been using for decades. The checklist should include the basic steps that a provider checks off each time the procedure is performed," he says.

When health care professionals fail to follow hospital policies and procedures or basic standards of care, it's not because they're evil or malicious. It's usually because they're overwhelmed with work, he says.

"We should not be pushing health care providers to their limits of endurance. Sooner or later someone who is so exhausted by overwhelming pressure to do more and more is going to make a big error," he says.

When an error occurs, the immediate response shouldn't be to blame or punish the person responsible but to determine what made it easier to commit the error, to forget to do something, or to overlook something important, he adds.

Hospitals should have a mechanism for addressing patient safety lapses when they do occur, Banja says.

The policy should spell out what a staff member should do if he or she observes a patient safety issue and should include a mechanism that protects the person who reports the lapse or carelessness, he says.

"Overwhelmingly, people do not like to point the finger at another person. Hospitals must establish patient safety policies that emphasize that staff members should report patient safety lapses," he says.

In addition, hospitals must respond when patient safety problems are reported.

"It really boils down to leadership. Leaders all say they're concerned about patient safety, but they must constantly and relentlessly practice what they preach," he says.

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# Orientation sessions help families in LTACs

*Transition from acute care often difficult to accept*

Recognizing that the transition between the short-term acute care hospital and a long-term acute care hospital (LTAC) is difficult for

patients and families, Mesquite Specialty Hospital in Dallas has begun weekly orientation sessions to help family members understand what an LTAC is and how the services a patient will receive there are different from what happens in the short-term acute care hospital.

"We think it's important for family members to feel comfortable with the LTAC setting and the care the patients will receive. We hope that the orientation sessions will give them a higher level of comfort with the facility and having their loved ones admitted," says **Cathy Campbell**, BSN, MBA, CHC, FACHE, director of case management.

The first 72 hours after admission are the most difficult for the family and the patient, Campbell says.

Many of the patients originally expected to be hospitalized and then go directly home. Others don't understand the concept of an LTAC and believe that they are being transferred to a nursing home, she says.

"In the short-term acute care hospital, patients are admitted and discharged very quickly. Our patients are very sick, with a lot of co-morbidities, and they stay for a long time. Families often have a difficult time accepting this," she says.

The orientation sessions are designed to answer the questions and concerns that patients and family members have early in an LTAC stay and to make the transition easier. Information includes the mission and vision of the hospital, what services LTACs provide, the plan of care, and the expected length of stay.

The family orientation session lasts about 45 minutes, with time at the end for questions.

The sessions are not mandatory, but staff encourage family members to come.

The hospital administrator opens the session and presents the hospital's guidelines and the principles of treating patients.

"Business development is involved to educate them on what the plan of care is all about," Campbell says.

Representatives from case management, nursing, physical therapy, occupational therapy, speech therapy, respiratory therapy, and dietary also discuss the services their departments provide.

The orientation sessions are a good way for the staff to get to know the family members and vice versa and to start the communication process, Campbell points out.

"Quite a few of our patients are so sick that family contact is very important. We educate them on what we can do for the patient and make sure that we understand their expectations," she says.

In addition, staff offer individual patient and family conferences in which they discuss the specific services the patient will require, the treatment plan, and the expected length of stay.

"In short-term acute care hospitals, there is no penalty if patients go home early. Federal regulations require that patients in an LTAC have a length of stay of 25 days or longer, and there is a penalty if patients stay less than 25 days," Campbell says.

This means that before patients are admitted, case managers must ensure that they need a 25-day stay to prevent the facility from being penalized for accepting short-stay patients and make sure that the patients and family members know that the stay will be long-term.

"We tell them the expected average length of stay is 25 days. Sometimes they hear and understand this. Other times, they want to leave after 10 days. That means a penalty for us, and it throws up a red flag for CMS," Campbell says.

The hospital's case management department includes one social work case manager and two RN case managers who coordinate care for 40 patients, with each staff member responsible for about 13 patients.

The staff are cross-trained to fill both the case management and social worker roles and work as a team to collaborate on care for the patient.

At Mesquite Specialty Hospital the case management staff are assigned by physician, which enables them to develop a close working relationship with the doctors.

One of the challenges of case management is to educate the physicians that patients must meet medical necessity for an LTAC stay and that an LTAC has to meet regulations for treatment that are different from those in the short-term acute care hospital.

"An LTAC is not an all-inclusive setting. Physicians must focus on the reason that patients are admitted to the LTAC rather than ordering diagnostic work-ups," she says.

For instance, if a patient is admitted to an LTAC for ventilator weaning and is exhibiting symptoms that could indicate some type of cancer, it's not appropriate for physicians to order a test to determine if the patient has cancer.

"Our concern is to take care of the condition that brought the patient to the LTAC in the first place. Tests that typically are done on an outpatient

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# CRITICAL PATH NETWORK™

## Outreach program reduces readmissions for HF

*Nurse visits high-risk patients in home*

Readmissions among all heart failure patients dropped by 50% in the first year of Saddleback Memorial Medical Center's comprehensive heart failure program, which focuses on a smooth transition between the hospital and the community.

Patients in the program also show significant improvement on the Dartmouth Quality of Life Index, says **Louise Della Bella**, RN, MN, CNS, NEA-BC, executive director for care management, discharge planning, and social services.

"We use this index to determine if the patients are improving subjectively as well as objectively. We not only are keeping them healthier, we are improving their quality of life," she adds.

A key component of the program is the addition of a heart failure outreach coordinator who visits high-risk patients in their homes and works with their physicians to help the patients learn to keep their condition under control. The outreach program is funded by the hospital foundation.

"Heart failure is one of the major diagnoses for readmission to the hospital. We know that patients with heart failure are readmitted for a variety of reasons. We wanted to make sure we follow best practices while the patients are in the hospital, that we discharge the patients at an appropriate time, and that we follow up after discharge," says Della Bella.

Following the initial success of the program, the hospital has begun a pilot study using remote telemonitoring equipment.

"We hope that by using technology, we can reduce readmissions even more while freeing up the outreach coordinator's time to work with the patients who need it most," Della Bella says.

Patients in the pilot project use a Bluetooth-enabled wireless remote monitoring system that collects the patients' weight and other bio-metric data and transmits them to Saddleback's health information group of nurses, who monitor the data and either alert the patient's physician or **Laurie Carson**, FNP-C, MSN, heart failure outreach care coordinator, when there is an increase in body weight or other problems that could indicate an exacerbation.

"By taking a proactive approach, we can intervene before the patient's symptoms become severe enough to warrant hospitalization," Della Bella says.

A multidisciplinary team at the hospital identified the reasons heart failure patients are readmitted, including medication issues, excessive salt intake, and weight management problems, and developed a plan that begins with beefed-up education at the bedside.

"We make sure the patients understand the importance of following their treatment plan when they're in the hospital, and we recognize that patients go through a very difficult period when they get home. We make sure that those who are at highest risk for an exacerbation get a home visit as soon as possible after discharge," she says.

The care of the sickest of the sick patients — those with stage 4 heart failure — is coordinated by Carson, an advance practice nurse with years of experience in heart failure, who also worked with the hospital team to design the program.

About 95 patients have participated in the home visit program since it started in 2007.

"These are the patients who are at high risk for readmission and who are likely to have a really difficult time if they have a readmission. They are the patients who will have a high financial impact on the hospital," she says.

When patients in the program do come back

to the hospital, their consumption of resources is lower than patients who are not in the program, Della Bella says.

The program currently is limited to Medicare patients.

"Most managed care plans have disease management programs for heart failure patients. The programs are telephonic and don't provide the face-to-face assistance that we do; but these patients do have some support," Della Bella says.

When the heart failure case manager on the unit identifies a patient who is eligible for the home visits, she alerts Carson, who visits the patient before he or she leaves the hospital and works with the heart failure case manager to ensure that the patient has a smooth transition back home.

"The program is all about coordinating care for patients throughout the continuum of care, rather than just treating isolated events for the patient," she says.

The heart failure case manager on the unit starts the process of educating the patients about what they should do after discharge. She is responsible for the core measures and works with the nursing staff and the physicians to ensure a coordinated hand-off to Carson.

Before the patient is discharged, the hospital sends an introductory letter to the patient's physician, describing the program and asking for the doctor's approval for the patient to participate.

"The doctors have been extremely happy with the program. It reduces their phone calls and helps their patient manage better at home," she says.

Carson works with each patient's physician, usually a cardiologist, to develop processes of care.

"This program is a true collaboration between levels of care and clinicians. We aren't doing it in isolation. We want the physicians to know what is going on with their patients because it helps the patients keep their condition under control and enjoy a better quality of life," she says.

On her first visit, Carson completes a comprehensive physical assessment, goes over the information the patient received in the hospital, answers questions and concerns, and does a home assessment.

"We tailor our program to meet the patient's needs. The focus is on making the patient as independent as they can be in their care. We set goals and make sure that the patient and family members understand what we want to do," Della Bella says.

Depending on acuity, Carson may visit the patient in his or her home several times a week or as little as once a week to start.

"It's strictly dependent on the patient's condition. If they have a bad week, she may increase the visits. If they are managing independently, her visits are less frequent," Della Bella says.

The program focuses on making heart failure patients more independent.

"We don't want to do for the patients. We want them to learn to do for themselves. We teach them what they can and cannot do, what symptoms indicate they should call their doctor, and what they should do to follow their treatment plan," she says.

For instance, Carson teaches patients when they should call their physician and helps them ask the right questions of their physicians but encourages them to make the telephone calls themselves.

She enters information on each patient in the electronic record so that when the patient comes back to the emergency department or is readmitted, the treatment team will have information on what happened when the patient was at home.

"Saddleback has a reputation for being the most high-tech hospital in Orange County. We are using our electronic medical record to help with the communication piece across the continuum of care," Della Bella says.

When patients are discharged with home health services, Carson collaborates with the home health nurse to ensure a smooth transition from home health to the heart failure program. She works with representatives from palliative care and hospice when patients decide they are ready for those services.

"Some patients don't want further treatment. They just want to be comfortable and pain-free. With this program, the nurse practitioner is able to initiate those conversations in the home and make sure the patient's wishes are followed," she says.

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# Center dedicated to patients over age 65

*Staff are trained to provide geriatric care, support*

The nation's first senior emergency center, opened by Holy Cross Hospital in Silver Spring, MD, is specifically tailored to meet the needs of a growing population of adults and provides care that goes beyond the typical emergency department assessment and treatment.

The Seniors Emergency Center at Holy Cross is

an eight-bed, separate, enclosed area of the main emergency department and is dedicated to the care of patients over age 65, says **Susan Spivock Smith**, RN, CRNP, PhD, geriatric nurse practitioner at the center. The center is staffed by two nurses, an emergency center physician, a geriatric social worker, and a certified nurse assistant.

"We operate on a model similar to a pediatric emergency department. Just as children are not small adults, older adults are not the same as younger adults. Having geriatric specialists who can recognize atypical presentations in this specialized population can help speed the plan of care and treatment and result in better outcomes," adds **Marcella Smith,** MSW, social worker at the center.

For instance, a younger adult who is having a heart attack will have symptoms of mid-sternal crushing chest pain, sweating, and nausea. In the older adult, the atypical presentation of a heart attack may be manifested as abdominal pain, change in appetite, or altered mental status.

"In the younger adult, when you hear hooves, you think horses; but in the older adult, you must thing zebras," Spivock Smith says.

The center opened Nov. 6, 2008. In its first year, the hospital provided care to more than 12,000 seniors in the emergency center, and more than 50% of them were admitted.

Among respondents to a patient satisfaction survey sent to patients three weeks after a visit, 98% say they would recommend the center to friends and families.

"The emergency department is a frequent point of entry into the health care system for seniors. Holy Cross Hospital has always been senior-friendly, but we wanted to expand the services we provide to older adults," says Smith.

Patients over 65 who are not experiencing an acute event such as a heart attack or a stroke are triaged to the senior emergency department or Express Care, Spivock Smith says.

About 75% of seniors who present to the emergency department meet the criteria for the senior emergency center, she adds.

Spivock Smith and Smith also see senior patients in the main emergency department.

Almost half of the patients seen in the emergency department have had a fall. The most common conditions seen in the Senior Emergency Center include abdominal pain, shortness of breath, diarrhea and vomiting, dehydration, urinary tract infections, or change in mental status.

"We assess problems that older adult patients may be having beyond the reason they came to the emergency department. For instance, if someone tells us they can't pay for their blood pressure medicine or can't afford groceries, we help them access the appropriate resources that can help. As a social worker, I have the expertise to provide support, compassion, and respect to these vulnerable elders," Smith says.

When the patient arrives at the emergency center, the RN on duty conducts a comprehensive assessment that includes the patient's living conditions, support at home or in the community, mobility issues, and whether they have been in the emergency department during the last 72 hours and the last 30 days, or have been hospitalized in the past three months.

As part of the assessment, the RN records family concerns, caregiver stress, or other issues that may affect a safe discharge.

"We look at the potential for readmissions from the get-go so we can take measures to make sure they can transition safely into the community and prevent them from coming back," Spivock Smith says.

If patients are taking five or more medications, the staff alert the pharmacist, who assesses the medication to determine if there is an inappropriate drug or dose. The pharmacist communicates the information to the physician so he or she can make changes to the medication regimen.

"A lot of times, medication can contribute to falls. The patients may not be taking the right dosage or the right class of drugs. In those cases, the pharmacist makes a recommendation to the physician to prescribe a more appropriate drug," Spivock Smith says.

The Senior Emergency Center staff have access to all the resources the hospital provides.

The team of Spivock Smith and Smith team is able to help avoid unnecessary hospitalizations by identifying proactively what issues might be a roadblock to discharge.

For instance, if a patient has fallen, they can request a physical therapy evaluation in the senior emergency center. A physical therapist can assess the need for equipment and make recommendations for home care services to assist the older adult with transitioning home safely.

"We've also helped facilitate admissions for patient who were not safe to go home. We are involved with discharge planning for these patients so when they do leave the hospital, it's to a safe environment," Smith says.

If patients are admitted to the hospital, Smith and Spivock Smith follow up with the case manager and social worker on the unit, alerting them of any issues they have observed.

"This means they are a step ahead in the discharge planning process because they already have the information we have gathered on their living situation, caregiver availability, and any mobility or cognitive issues," Spivock Smith says.

When patients are being discharged from the senior emergency center, Spivock Smith takes an active role in making sure they understand their discharge instructions and get an appointment with their primary care physician for a timely follow up.

"We take a holistic approach to the care the patient receives through the entire continuum of care. We found that sometimes patients come back to the emergency department because they don't understand their discharge instructions and they don't get the appropriate follow up after discharge," Spivock Smith says.

Smith calls the patients the day after they are discharged from the emergency department to make sure they have everything they need at home.

"Home may be a nursing home, a group home, an assisted living center, or the patient's own home," she says.

She asks if they've gotten their prescription filled, whether they have an appointment for follow-up care, and answers any questions.

If there are any barriers to care, Smith works with the patient and family to meet those needs.

For example, when patients tell Smith that they couldn't get an appointment with their doctor for several weeks, she asks for permission to call the doctor and see if she can get the appointment in a more timely manner.

"We know that if patients are not seen in a timely manner, symptoms may not be well controlled and they'll end up back in the hospital. We work to get them an appointment with a doctor in one or two days," she says.

The Spivock Smith-Smith team facilitates care along the continuum. They have a collaborative relationship with the doctors in the community.

"The physicians trust our judgment and are very receptive to our requests," Spivock Smith says.

Sometimes the team provides help and support for someone other than the patient and looks beyond his or her physical complaints, Smith reports.

For instance, a man who came in complaining of abdominal pain is the primary caregiver for a wife with cognitive issues and was experiencing a lot of stress related to caregiving.

"While the staff took care of the patient, I met with the daughter, who agreed that something needed to be done to relieve her father. We arranged for adult care to get relief for the father," she adds.

**Kevin J. Sexton**, president and CEO of the hospital, came up with the idea of the special emergency department for seniors because of the growing senior population in Montgomery County.

"Within the next 10 years, the senior population is expected to grow five times faster than everyone else. The growing number of seniors in this country presents a tremendous challenge to our health system, and it is our responsibility to respond in a way that is both sensitive and sustainable," Sexton said.

The hospital formed an advisory committee that included clinicians as well as a focus group of seniors and worked closely with Bill H. Thomas, MD, an elder care expert, and his team at The Erickson School at the University of Maryland to design the area and create a senior-friendly space.

The Holy Cross Hospital auxiliary earmarked the money from its gala in 2007 for the senior program.

Patients in the focus group said they wanted to be kept warm, kept comfortable, and kept informed during their emergency department stay.

The hospital modified what had been an overflow area for the Express Care department to include six bays, two private patient rooms, and a room for family consultations.

The environment was designed to reduce anxiety, confusion, and risk of falling.

"We focus on making the experience as pleasant as possible. The patients often are here for several hours," Spivock Smith says.

Features used throughout the senior center include soft colors; noise-abatement features; non-slip, non-glare floors; non-glare lights with dimmers; hand rails; and grab bars. The area has a blanket warmer and a nursing station designed for increased visibility.

The rooms have pressure-reducing mattresses, clocks, calendars, telephones with large buttons, a dry-erase board, a flat-screen television with a speaker that can go under the pillow for patients who are hard of hearing, and comfortable chairs for family members.

"We encourage family members to stay with the patients. We strive to keep them informed. We let them know what tests are being performed and when we expect the results back. It has been our experience that patients and family members become less anxious when they know what to expect," Smith says.

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(Continued from page 86)

basis are not appropriate in an LTAC. If we find the patient has cancer, we can't treat it here. The doctor needs to wait until the patient is stabilized to have the test and then go from there," she says.

The case managers work closely with the physician to make sure that the tests and procedures they order are appropriate in the LTAC setting.

If the case manager feels a particular procedure isn't appropriate, he or she calls the physician and asks if the test or procedure is necessary at this time or if it could be completed after discharge.

"Our concern is taking care of what the patient is hospitalized for. If it's a serious and life-threatening situation, we send the patient to a short-term acute care hospital. If it is a diagnostic work-up, it should be done on an outpatient basis after the patient is discharged," she says.

The case managers work with the physicians to eliminate duplicate tests and procedures.

For instance, if a physician orders an echocardiogram and the case manager reviews the chart and determines that the patient had the procedure four days previously at the acute care hospital, the case manager gives the doctor the results and asks if the patient needs a repeat procedure.

"Our case managers are attuned to what tests and procedures the patient had at the previous hospital, and often the doctor doesn't know," she says.

When Mesquite Specialty Hospital gets a referral, the LTAC's liaison visits patients in the short-term acute care hospital, determines if they are appropriate for admission, talks to the patients and their families about what will happen during an LTAC stay, discusses the LTAC's two areas of expertise — ventilator weaning and wound care — and shares the hospital's outcomes data with the family.

The LTAC staff review the paperwork for medical necessity and to determine that the patient can benefit from a stay.

Staff reviewing the file include the case manager, nursing director, respiratory therapy, physical therapy, and pharmacy.

"The clinicians review the chart to see if we need any more information or test results, and the pharmacist makes sure we have the drugs they need," she says.

Since the LTAC is subject to scrutiny from the Recovery Audit Contractors and other CMS auditors, making sure that patients meet medical criteria is a must, Campbell says.

In order to meet medical necessity for admission to an LTAC, patients must be too sick to go home or be transferred to a skilled nursing facility, Campbell says.

"All of our patients have high-level needs. They aren't ready to go home after a short stay. The acuity and severity of the patients is much higher than in a regular hospital," she says.

Most patients have been in the intensive care unit at the short-term acute care hospital. They stay at least 24 hours in the ICU at Mesquite Specialty Hospital. Then they are moved to the high-level observation bed that is on the medical-surgical unit but close to the nursing station. Nurses who work on the high-level observation unit have a caseload of just three patients.

The case managers see patients the day after admission and conduct a thorough assessment, including determining the patients' expectation for the stay.

The team reviews every patient in the hospital once a week, identifying barriers to recuperation and barriers to discharge. They look at whether the patient is likely to go home or will need another level of care after discharge from the LTAC.

The case managers call the families after the team conference to let them know the patient's condition and any changes in the care plan.

"We manage the whole concept of the patient's care. We manage the patient every day, making sure that everything happens in a timely manner and is appropriate for that particular patient," she says.

The names of everyone caring for the patient are on a magnetic board in the patient's room.

"Everyone knows who the case manager is, and if something comes up or they have questions, they know who to talk to. The case managers work closely with the patient advocates who answer complaints and concerns," she says.

As the case managers make arrangements for discharge needs, such as home health or durable medical equipment, they counsel the family about what will be best for the patient.

"It's not always what the patient and family want to hear, but we always communicate what is safe for the patient. The expectations for patients can change every few days. They may be improving but then have a set-back. We stay constantly in communication with the family so they know what to expect," she says.

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# 'Attitude adjustment' is key to ED success

*Presenting patients get a bed in three minutes*

In the face of steadily increasing volumes (13,000 between 2008 and 2009), the emergency department (ED) at Peninsula Regional Medical Center in Salisbury, MD, has improved all of its operating statistics, achieving a door-to-bed time of three minutes and a door-to-doc time of 21 minutes.

While such a performance could not have been accomplished without more efficient processes, the ED leadership team insists that the single most important element in their success has been a change in the way physicians and nurses relate to each other.

"We had some leadership changes 18 months ago with a renewed emphasis on our relationship and teamwork with nursing and the hospital," says **Clark Willis**, MD, medical director of the ED. "Most of the positive changes that have occurred, in my opinion, are process, structure, and throughput changes that resulted out of that collaboration." Willis says it is "amazing" what can be accomplished when physicians and nurses link hands and work together, instead of blaming each other and pointing fingers.

**Susan Castrignano**, RN, BSN, nursing director, agrees. "A lot of it had to do with leadership," says Castrignano, who adds that she and Willis came to their positions about the same time. "When the staff saw we actually talked to each other and were on the same plan and shared the same ideas, and that we had support for each other, support from the physician group to nursing and vice versa, little by little people saw you as a leadership team and not me representing the nurses and he representing the physician team," Castrignano says.

One simple but important change involved the structure of staff meetings, she says. "Now we have one big meeting, whereas we used to have a staff meeting for nurses and a departmental meeting for doctors and some nurses," Castrignano says. "Now we are all in one big room together. We hear the same message at the same time."

Willis says, "We sat down and talked about what we thought made a difference." After an ED expansion, "we had more space, new servers to run the EMR [electronic medical record], but we both agreed that we had to make a renewed initiative of working together," he says.

In the past, there was much more division about who was responsible for different activities and whether errors were the doctor's fault or the nurse's, Willis says. "In trying to focus on how we could work better together, we eliminated job-title-specific details," he says. "Meetings were more about everybody seeing the bigger picture of where we were headed and what we were trying to do. The key questions became what was best for the patients and how we could best serve them, regardless of whose area it was." ■

# 'Line at the door' is tackled first

When the ED leadership team at Peninsula Regional Medical Center in Salisbury, MD, set out to improve throughput, the first thing they tackled was the line at the door, says **Clark Willis**, MD, medical director.

"Patients were lined up at one window trying to get registered and triaged," Willis recalls. "The attitude was that we didn't 'own' the patient until they got past that wall."

Process changes to address this issue included putting a greeter in the waiting room to be sure patients with more urgent needs were seen first and streamlining the triage process so patients would get to treatment more quickly.

**Susan Castrignano**, RN, BSN, the nursing director, says, "The ED had been expanded from 19,000 square feet to 41,000 square feet, but as much input as we had into the design, when our volume went up, we still had issues. Instead of a full triage, if there was an open bed, we started bringing the patients straight back. You could bring four or five people back at the same time, and it all happened in parallel."

To help make this possible, changes were made to the electronic medical record screen to prevent nurses from performing a full triage and directing

them to just do a "mini-screen," Castrignano says.

"The content of the triage was not changed, but the team felt it was important to separate the screens and have the triage nurses do the first initial screen and the primary nurse who would be taking care of the patient the second part, which contains the past medical history and medication reconciliation," she says.

The traditional culture of the staff was to do as much as possible in triage and not to dump the work on the primary nurses, Castrignano says. "But when the question came up as to what was best for the patient, and the goal is to have the patient see the provider, the majority of the nurses were supportive about the process change," she explains.

As with all of the changes made in this ED, teamwork was a critical element. Willis says. "We involved the nurses in the decision-making. We had a focus group process improvement, rather than just pronouncing the change."

The nurses received one-on-one training from other nurses. They walked through the new screening process and seeing how to get patients back to the bed more quickly. "The doctors were recipients of education, too, since they had to hop in and see those patients with the understanding that they may not have been completely triaged," Willis says.

The new attitude of cooperation manifested itself when a problem arose with the express care unit. "When we started to bring patients straight back, we had to protect express care, because staff tended to grab mid-level people to protect the doctors," Willis says. "They were poaching from express care to fill their own needs. We agreed to protect express care staff; that doctors would not pull mid-level staff, and nurses would not pull nurses or techs."

The result? Despite the fact that express care saw a 21% increase in volume, its throughput went from an hour and a half to under 60 minutes. ■

# Wait time too long? Reduce risks this way

To reduce legal risks, the best strategy is to "show diligence," says **Linda M. Stimmel**, JD, a partner with the Dallas-based law firm of Stewart Stimmel.

Document your ED's efforts to provide adequate

## CNE questions

21. What caseload should med-surg case managers have in order to effectively coordinate care, according to Cory Gutzezahl, MD?
A. 15 to 20
B. 20 to 25
C. 25 to 30
D. 30 to 15

22. According to John Banja, PhD, hospital case managers are in a good position to observe patient safety lapses since they are involved with patients throughout the stay.
A. True
B. False

23. Federal regulations mandate that patients in a long-term acute care hospital have what minimum length of stay?
A. At least two weeks
B. At least 30 days
C. At least 25 days
D. At least six weeks

24. How many minutes is the improved door-to-bed time in the ED at Peninsula Regional Medical Center?
A. 1
B. 3
C. 5
D. 10

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

## 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 **this issue**, you must complete the evaluation form provided and return it in the reply envelope provided to receive a credit letter. ■

staffing, and educate staff and physicians on improved triage techniques, such as attendance logs on inservices to improve triage.

Here are other risk-reducing practices:

**• Address concerns of a patient or family member by providing an immediate reassessment.**

**Emory Petrack**, MD, FAAP, FACEP, a medical-legal consultant and principle of Shaker Heights, OH-based Petrack Consulting, says, "When someone comes to a staff member, whether a physician, nurse, clerk or anybody, and expresses concern about their loved one, do not blow that off."

**• Post signage and verbally inform patients to let the nurse know if their condition worsens.**

"On some level, you are putting that responsibility on the patient," says Petrack. "I think it's fine to let people know that it's a busy ED, and you need to work with us to make sure you are taken care of."

**• Keep patients informed continuously.**

**Jonathan D. Lawrence**, MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA, says, "From a consumer standpoint, people often don't mind waiting, as long as they know what they're waiting for. But when it's busy, usually the triage nurse doesn't have time to go out there and make nice. And those are exactly those times that are most tension-filled."

Instead, an administrator might tell patients that an ambulance just brought in additional patients from a motor vehicle crash, and the ED staff are doing the best they can but an exact wait time can't be given. ■

# ED cuts LWBS from 5% to 0.5%

*Input required from several departments*

Recognizing that ED wait times and throughput are affected by the entire hospital, the leaders at King's Daughters Medical Center in Ashland, KY, engaged all the departments that interface with the ED and slashed the rate at which ED patients leave before treatment from 5% to 0.5%. This accomplishment is all the more remarkable because the ED sees 76,000 patients a year and volume has not declined during the implementation period.

During that same time period, turnaround time for admitted patients decreased by 22%, from 312 minutes to 242 minutes, and turnaround time for patients discharged from the ED fell by 9%, from 183 minutes to 166 minutes. "We still have a long way to go," says **Mona Thompson**, MBA, RN, CPHQ, CENP, vice president of patient services and chief nursing officer.

**Brandi Boggs**, RN, MSN, director of emergency services, says, "Throughput is a high priority for us for lots of reasons: patient satisfaction, quality of care, overall decline in length of stay."

Senior leaders outlined the goals and methods to achieve them. "We had a goal of reaching best practice in terms of left without being seen as defined by The Advisory Board — which is 0.55%," says Boggs. *(Editor's note: The Advisory Board, based in Washington, DC, is a provider of performance improvement services to the health care and education sectors.)*

Thompson says, "Brandi and her team came up with this plan. She involved radiology, bed placement, doctors and nurses, housekeeping, the pharmacy, the customer satisfaction team, the laboratory, case management, social workers, and IT — all the stakeholders." These stakeholders worked on actions specific to their discipline needed to achieve the 0.55% goal, she says.

"That's really important," says Thompson. "Teamwork is important to us, and the team members who do the work know how to make things better." So, for example, ED charge nurses and triage nurses accept responsibility for patient-left-without-being-seen rates and actively interact with patients to explain the benefits of receiving a medical screening exam, she says.

After several months of meetings, the plan was implemented in February 2009. Boggs says that in the ED itself, "one of the things we do differently now is triage patients directly to the back when there is an open bed. Triage is a function, not a location. If there is an open bed, and you bring the patient straight back, it increases quality of care and customer satisfaction."

This step eliminates the "funnel," Thompson says. "Most ED teams will tell you that patients arrive at triage in clusters, not in a steady stream, so if you funnel all of them through one or two triage nurses, it makes it slower for the last person in the cluster," she says. Now if there is a bed open, the patient can be triaged by the bedside nurse, Boggs says.

"We also do hourly throughput assessments in the ED," she says. "We developed a worksheet

where we can look at things that define throughput — patients in the lobby, current wait time, boarders" who are waiting more than two hours for a bed. Based on the worksheet, the charge nurse will assign a color (green, yellow, orange, or red) to indicate throughput status.

If there is a problem, all of the departments will swing into action. This team approach has led to steady progress, says Thompson, who notes that the 0.5% figure was first achieved in January 2010. "In the last two fiscal years [which end in October], we averaged 4.55% and 3.49%, respectively," she reports. "Year to date, we are at 1.33%." ■

## Other units can 'rescue' the ED

The decrease in the rate of ED patients leaving before treatment at King's Daughters Medical Center in Ashland, KY, from 5% to 0.5% was not achieved by the ED alone. It took a concerted effort on the part of all of the major departments that interface with the ED.

Hourly throughput assessments in the ED result in the charge nurse assigning a color (green, yellow, orange, or red) indicating the current throughput status. "Based on that level, different actions are taken to elevate the urgency of getting resources to the ED to get it moving," explains **Mona Thompson**, MBA, RN, CPHQ, CENP, vice president of patient services and chief nursing officer.

A page is sent to the hospital's leadership council twice a day indicating the overall status of the organization and specifically the ED. This page goes to every individual with the title of manager, director, or above.

"When the ED gets to orange or red [indicating that throughput is becoming seriously impaired], we do individual hourly pages until that is resolved," says Thompson. This page includes leaders who are at home, adds Thompson, noting that the previous night, a Code Orange was called at 1 a.m. "The expectation is that the entire leadership team will either come in or call to ensure their department is appropriately responding to meet the needs of the ED," she explains.

**Brandi Boggs**, RN, MSN, director of emergency services, says, for example, "if we are at orange, on the inpatient side, they will look at their units to



## CNE OBJECTIVES

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

- identify the particular clinical, administrative or regulatory issues related to the profession of case management
- describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the health care industry at large
- discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

## COMING IN FUTURE MONTHS

- Ways your peers are reducing length of stay
- The latest IPPS news from CMS
- Smoothing transitions to reduce readmissions
- How ICD-10 will affect case managers

see if any patients are ready to go home and discharge them in a timely manner to free up a bed. Housekeeping is notified so they can get the beds cleaned."

Thompson adds, "The lab may put an extra phlebotomist in the ED, or the radiologist may call out another tech, depending on what the needs of the particular patient population are at that time. Pages may even be sent to the laundry to make sure there are adequate linens or to have them bring an extra linen cart." ■



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