HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

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AHC Media

Forget on-the-job training — You must have a formal orientation

It happens again and again at hospitals across America. A new case manager joins a department and receives minimal on-the-job training from another case manager who is trying to do his or her own job at the same time.

"Historically, there is a woeful lack of education for incoming case managers in a hospital environment," says **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

A nurse is on the floor one day and a case manager the next day, Kizziar says. "The basic problem is that the people who end up telling the new person what their role entails became a case manager the same way," she says. "This creates a vacuum in learning and competencies."

It's not that an experienced case manager teaches a new case manager something wrong, but lack of training could result in duplication of effort or continuing to do tasks that have no value, Kizziar adds.

Teresa Fugate, RN, BBA, CCM, CPHQ, vice president, case management services for Covenant Health System, a seven-hospital system with headquarters in Knoxville, TN, says, "As case managers become com-

Special focus this month: Case management orientation, training

In the past, many nurses became case managers by the "poof method." One day they were a floor nurse, then poof, the next day, they were a case manager. With today's emphasis on ensuring that documentation is complete, making sure admission status is correct, reducing length of stay, avoiding readmissions, and meeting payer requirements, case managers need detailed and extensive training to do the job right. In this issue, we'll discuss how you should develop a training and orientation program and what it should include. We'll look at whether floor nurses are the right candidates for the job and how case managers should dress to make a good impression. We'll describe in detail one hospital's peer interviewing process and orientation program.

We hope you enjoy reading this special issue of *Hospital Case Management*.

fortable in the role, they tend to forget the basics that they perform automatically, and they tend to leave them out when they're training a new person. There are so many strict compliance and discharge planning requirements that it's hard for new case managers to remember them all." For example, a seasoned case manager might forget to mention that when patients go from observation to inpatient status, the stay starts on the date and at the time the physician wrote the order, Fugate adds.

"People "don't just wake up" with the ability to perform case management, Kizziar says. "Nursing schools, social work schools, and therapy schools teach basic clinical applications," she says. Graduates have to pass an examination before they can practice, Kizziar says. "When people sub-specialize into case management, the thinking tends to be that because someone is a nurse or a social worker, they should know how to be case manager, but that's not true," she says. "It's a specialty into itself."

Case managers typically are trained in pieces that focus on the basics, Fugate says. "Then they're put on the unit and expected to know what to do. It takes at least a year of practice and additional training for a person to become competent and comfortable in performing a case management job," she says.

It's the case management leader's responsibility to make sure that new staff have the proper orientation, and often that means revising your training program, says **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management, at Lutheran Medical Center in Brooklyn, NY, and partner and consultant in Case Management Concepts, a case management consulting firm in Dallas.

Case management orientation should include didactic as well as preceptor experiences. This means you should develop classes and a collection of reading material for new case managers, as well as partnering them with a preceptor, Cesta adds.

The best time to look at your case manager

EXECUTIVE SUMMARY

In today's complicated healthcare arena, on-the-job training isn't enough to prepare new case managers to handle documentation, care coordination, compliance, and discharge planning requirements. Hospitals need a formal program to orient and train case managers.

- Base your training program on the hospital administration's expectations for case managers, and consider including case managers in the development process.
- Training should be a minimum of four weeks and include didactic and preceptor experiences. Offer training and educational opportunities for your experienced staff as well.
- Floor nurses who want to be case managers should have an opportunity to spend time with case managers to find out what the job entails.
- Insist that your case management staff dress professionally.

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training process and consider revising it is when you don't have any empty positions, suggests **Beverly Cunningham**, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital, and partner and consultant in Case Management Concepts. "We all get so busy, and then we hire someone new and realize that our training and orientation process needs updating," Cunningham adds.

Before developing a case manager training program, case management directors should meet with their hospital administration and find out what the hospital expects the case management department to accomplish, Kizziar says. Design your training program around that information, she says. Develop an outline of what the hospital administration expects of the case management department, set priorities for meeting the expectations, and determine what you have to do to get it done, she says.

Cesta suggests appointing an orientation task force to develop the orientation process and update it as needed. The task force should include experienced case managers as well as those who have gone through orientation recently. Kizziar adds, "Create an orientation process so new people will have tools, instructions, and the information they need to meet the objectives, and so that each new case manager has a go-to person who also has been trained."

A successful training and orientation program should move staff members from novice to expert and from good to great, Cunningham says.

The program should include basic classroom orientation about case management in general and the particular area where the new case manager should work, followed by one-on-one mentoring from another case manager who uses a check-off sheet listing each objective that the case manager should meet, Kizziar adds.

Any curriculum should address the core competencies of case management in your department, Cunningham says. Competency measures should outline what needs to be done to demonstrate that the competency has been learned, the process followed for performing the competency correctly, and information that the case manager must have to provide effective case management, she says.

Basic competencies are those that are performed daily. Immediate competencies, such as development of case management plans, are those that are performed less frequently. Expert competencies, such as managed care contract negotiation, are performed infrequently, Cunningham adds.

"The first piece of designing or revamping a competency program is to determine what competency measures to focus on and to make sure they are measurable," she says. "The impact on the organization, the patient, and the individual should be measurable and have time-specific intervals associated with setting goals."

SOURCES/RESOURCE

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- To order a webinar by Toni Cesta and Beverly Cunningham, "Designing Case Management Orientation: Simple Solutions to Educate Staff and Reduce Turnover," produced by AHC Media, publisher of Hospital Case Management, log on to www.ahcmedia.com. Under "View by Specialty," select "Case Management." ■

Need great CM training? Focus on the basics

Adapt curriculum to experience

New case managers should have a minimum of four weeks of orientation that can be expanded if the employee needs more time, says **Beverly Cunningham**, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital, and partner and consultant in Dallas-based Case Management Concepts.

The first 30 days of case manager training should focus on details such as policies and procedures, roles of case managers and social workers, information on the hospital and the software system, patient flow, and the organizational chart, Cunningham says.

Have your new employees spend time familiar-

izing themselves with the policies and procedures manual, and make sure it's available as a reference tool, she adds.

Adapt the orientation curriculum and educational topics to each individual employee's experience, suggests **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY, and partner and consultant in Case Management Concepts. "If someone has 10 years experience, they don't necessarily need to go through the basics, but they do need to learn how things work in your hospital and on the unit to which they are assigned," Cesta says.

However, don't skip the preceptor part of orientation even if the new employee is a highly experienced case manager, she adds. "Experienced case managers still need to go through the preceptor process so they can understand how your hospital does things," Cesta says. "You might shorten the preceptor period for an experienced case manager, but you shouldn't eliminate it entirely."

During orientation, the case management director needs to have frequent contact with the new employee. Cunningham recommends that case management directors meet with new employees and the person orienting them every week and talk about how the week went and what will happen the next week. "This is a good opportunity to learn how the orientation program is going and which staff are good preceptors as well as those who might not be so effective," she says.

Never shorten the training program even if the new case manager and the preceptor are desperately needed on the unit, Cunningham advises. "Sometimes, the training process starts out with good intentions, but somebody takes medical leave and the new case manager is put out on the floor alone. It's a big mistake to look at the moment and not at the future," she adds.

If you are experiencing staff vacancies, bring in a per diem case manager so the new person can continue with their orientation, Cesta suggests. "Some case management directors may argue that they don't have the money for a per diem employee, but it will save money in the long run," she adds.

The staff chosen to orient new hires should be those who like to preceptor and who have demonstrated an ability to do it well, says Cesta, adding not all senior staff members are good preceptors. Medical City Dallas brings in an expert PRN social worker, who once worked full-time for the department, to provide orientation for new employees. Cunningham says, "When she was here, she was so good in orientation, but she had children and has transitioned to PRN to raise her family. She focuses on orientation so the new employee doesn't have to follow someone around while they do their job." ■

Experienced CMs? Offer ongoing training

Keep staff educated to reduce turnover

Training shouldn't stop after case managers finish the training and preceptor period. Instead, training and orienting staff should be an ongoing process, says **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY, and partner and consultant in Dallas-based Case Management Concepts.

Retaining staff often is dependent on how the case manager was recruited and educated, and how the education continues after the employee is on the job, Cesta says.

"We often focus so much on the new staff that we forget the old staff," she says. "The cost of turnover is very high. There is nothing worse than investing a year in a person and having them move on."

As part of its efforts to beef up case manager training, Covenant Health System is revising its Case Management University, a comprehensive course with multiple modules, says **Teresa Fugate**, RN, BBA, CCM, CPHQ, vice president, case management services for the seven-hospital system with headquarters in Knoxville, TN. Every new employee in the case management department will be required to go through the training, Fugate says. In addition, Covent Health System is developing learning modules on topics that all case managers will have to complete on their own every year. The modules contain information on compliance issues and discharge planning requirements that have changed or that people tend to forget, she says.

Fugate is working with the health system's education department to develop the modules. "The basics are already there, but we're updating the information and making it more comprehensive," she says.

Hospitals have been slow to support outside

education and development for case manager, particularly as it relates to professional organization, says **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm. Few hospitals support case management certification, Kizziar adds. "A lot of the disconnection has been because hospital management doesn't appreciate the value of case management because we, as case managers, have not promoted ourselves," she adds.

The Case Management Society of America (www.cmsa.org) and the American Case Management Association (www.acmaweb.org) offer online educational opportunities for members, and both sponsor educational conferences every year, Kizziar adds. "There are a lot of online educational opportunities for case managers," she says. "Many of them are generic and aren't focused on one area of practice, but these classes give a general overview to someone who never has been in the case management arena." ■

Do floor nurses make good CMs? Yes and no

Explain what the job entails

Many floor nurses tend to look on case management as a glamorous job. "Case managers wear street clothes," says **Teresa Fugate**, RN, BBA, CCM, CPHQ, vice president, case management services for Covenant Health System, a seven-hospital system with headquarters in Knoxville, TN. "Historically, they've had weekends and holidays off. There's no heavy lifting or cleaning up patients."

Consequently, in most hospitals, when nurses on the floor make the decision to become case managers, they have no idea what they're going to be doing until their first day on the job, says **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm. The government regulations, extensive paperwork, and attention to detail the job requires makes it a challenge for nurses to adjust to their new role, Kizziar says.

Fugate adds, "We've had people come into case management from nursing, stay 90 days, and beg to go back to nursing. All of the payer requirements and other hoops case managers have to jump through create a lot of stress, particularly for people who are accustomed to spending more time with patients than doing paperwork."

Case managers need to think on a broader scale than nurses, Kizziar says. Nurses practice hour by hour observing and evaluating patients, providing treatment, and providing direct care, she adds.

Nurses must change their focus from the plan for the day to developing a plan for the stay, while looking ahead to the discharge process, adds **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY, and partner and consultant in Dallas-based Case Management Concepts. They have to make the transition from an hourly position with overtime, after-hours, and weekend differentials to a salaried position, Cesta adds.

When nurses transition into case management, they typically don't understand who the payer is, how the hospital is paid, and how what they do today impacts on the next level of care, she points out. At the same time, hiring floor nurses from your hospital has its advantages, Cesta says. "Pulling people from the bedside brings current clinical knowledge," she says. "They already have a relationship with the physicians, the rest of the staff on the unit, and an understanding of how the unit functions."

If staff nurses are interested in becoming a case manager, have them spend time with case managers before they take the job, says **Beverly Cunningham**, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital, and partner and consultant in Case Management Concepts. "Most nurses on the floor have no idea of the role of the case manager even if they see them every day," Cunningham says. "It is valuable for them to spend time with a case manager so they'll understand aspects of the job they might not know about, such as trying to get information to payers."

Fugate intends to train some of the health system's staff nurses to perform PRN case management. "We want to open up Case Management University to any nurse who is interested," she says. "If they want to move into case management, they will shadow a case manager as well as going through the classes."

Fugate has requested that nursing assign new nurses to spend time in the case management department to learn how the department works and the role it plays in patient care. "We are considering having any nurses who want to become

case managers to shadow a case manager for a day to better understand the job and whether it is something they want to do," she says.

When there's an empty position, evaluate the needs of the department, rather than just filling the role, Cunningham says. "The department may need a strong leader or someone who is just a good, solid case manager with no desire to take a leadership role," she says.

A good case management candidate should have a minimum of three to five years of clinical experience, be flexible, have critical thinking skills, and have good communication skills, Cunningham says. "I can teach someone utilization management, but I can't teach them how to be flexible," she adds.

Once you have identified potential candidates, arrange an interview with members of your case management team, Cunningham suggests. "The interdisciplinary team has to work with the new case manager, and they should be involved in the hiring process. There have been times when I thought a candidate was a good fit, but the staff picked up on things I missed," she says. ■

To earn credibility, you must dress the part

Case managers should look professional

As she consults with hospitals, **B.K. Kizziar**, RN-BC, CCM, CLP, occasionally is horrified by what she sees case managers wearing.

"I see case managers who come to work dressed like they should be doing yard work. Case managers don't necessarily need to wear business suits and shoes with heels, but they do need to look professional and take pride in their appearance," adds Kizziar, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

She recommends that case management attire be standardized in some way to identify the role that the case manager is performing. "People need to know that case managers are important people in the hospital who have a lot of knowledge and expertise," Kizziar says. "The best case manager in the country may be coordinating care for a patient, but if she is sloppily dressed and has dirty hair, people are less likely to trust what she says. People equate professional dress with knowledge."

Case managers need to earn credibility and respect, and that won't happen if they're wearing jeans and a T-shirt, Kizziar point out. "Credibility doesn't automatically come with a title. You have to earn that," she says.

At Covenant Health, case managers are expected to dress professionally in business casual clothing. Many of them wear lab coats as well, says **Teresa Fugate**, RN, BBA, CCM, CPHQ, vice president, case management services for Covenant Health System, a seven-hospital system with headquarters in Knoxville, TN. "Case management needs to be elevated, and that won't happen if the case managers don't dress professionally," Fugate says. "Business casual looks more professional than scrubs."

At one facility, case managers wear dress pants and shirts with hospital logo and "case manager" or "social worker" on the front. The shirts are available in a variety of colors. "We wanted to create an outfit that they could wear with athletic shoes because they are running all over the hospital," Fugate says.

Case management orientation should include the hospital dress code and how case managers approach their patients, Kizziar says. Case managers should avoid standing at the foot of the bed and looming over the patient, she says. Instead, they should be at the side of the bed when they talk to patients, and, if possible, sit at eye level, Kizziar says. "I see case managers walk into a patient room and say 'Hi. I'm your case manager.' They don't introduce themselves and don't call patients by name. There's not much engagement there," she says. ■

Peers allowed to choose among CM candidates

New hires go through rigorous training

When Jewish Hospital and St. Mary's Healthcare, a health system in Louisville, KY, has an opening in the care management department, the final decision to hire a candidate is made by a team of peer interviewers.

"These are the people who are going to be working with the new care manager. They are trained on peer interviewing to ask the kind of questions that help them determine which candidates are right for our department," says **Bev**

(Continued on page 59)

CASE MANAGEMENT INSIDER
Case manager to case manager

You're only as good as yesterday's discharges — Strategies to demonstrate case management's value

By **Toni Cesta**, PhD, RN, FAAN
Senior Vice President
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[Editor's note: This month we include the first part of a two-part series on demonstrating the value of case management to your organization. We cover metrics to measure and goals for your department. In next month's issue, we'll continue with examples of benchmarking and case management report cards.]

Since the mid-1980s when case management moved into the hospital setting, departments have been struggling to find the best ways to demonstrate their department's effectiveness. Over the years, these metrics have become increasingly sophisticated and have moved beyond the realm of simply measuring length of stay or the number of discharges.

Every hospital budgets its expected discharges for the day, the week, the month, and the year. Invariably, members of your hospital's executive staff monitor these numbers routinely and are satisfied when the targets are met and are dissatisfied when they are not. So, often we are challenged to show our value in more than just discharges or length of stay. The measures are among the most challenging things we do and require a structure, goals, and access to accurate and timely information.

Hospitals are complex organizations, and outcomes take the efforts of many individuals working as a team. Case management outcomes often are the result of the efforts of the case managers along with multiple other departments and disciplines. This makes the measurement of case management outcomes complex and challenging.

Productivity measures often are the only outcome indicators used. These are typically measures of workload and include indicators such as number of clinical reviews completed each day, number of discharges to nursing homes or home care, or how many patients were seen by the case manager. The measures define the workload of the case manager or social worker but not the effect of that work on the organization.

Categorizing outcomes

To select the outcomes you would like to measure, a good first step is to consider them in more than one category. Examples of these would include financial, clinical/quality, service, regulatory compliance, and productivity.

The next question to ask is, "What data do I currently collect"? The department must identify what data are collected and/or reported, as well as who sees the data. Consider any data that are being reported by other departments, as the reporting of these data might be redundant and dilute the effect of the message that case management is trying to send out with its data.

Case management outcome levels

When considering which outcomes you will use, also keep in mind the fact that there are different level of outcomes. This means that some of the outcomes by be affected in one of three ways:

- Organizational outcomes: affected by multiple departments / disciplines
- Departmental outcomes: affected by the case management department
- Staff outcomes: affected by individual staff members.

If the outcomes you select are organizational outcomes, consider providing a disclaimer on your

report indicating that the outcomes are the results of multiple departments or disciplines. Providing a disclaimer like this will help to demonstrate the team philosophy of the case management department. For example, for an organizational outcome such as length of stay, the case management department may want to state that "case management is one of many departments and disciplines that have an affect on length of stay."

Financial outcomes

Financial outcomes are relevant as they relate to many of the functions performed through the case management department. Most of these outcomes are affected by case mangers as well as other departments and disciplines and are reflective of the over-all efficiency of the hospital. Members of the physicians' staffs have a significant impact on financial outcomes. Collaborating with the physicians' staffs can have a positive impact on resource utilization, length of stay, and over-all cost per case. *(See more on these outcomes, p. 57.)*

Consider these other metrics:

• Observation hours.

The average number of hours a patient spends in observation is an important metric. Patients who remain in observation for greater than 24 hours should be considered for conversion to inpatient status. The case management staff should work closely with attending physician to monitor and manage these timeframes.

The case management department also should track and trend the total number of avoidable days and compare this number to the total number of excess days. Excess days are the total number of hospital days beyond the geometric mean expected length of stay for all discharges. Not all excess days are avoidable, and the case management department should report the variance between the avoidable and excess. By doing this, the hospital can better understand which excess days are truly avoidable and focus on these for performance improvement.

• Clinical /quality outcome metrics.

The case management department's effect on the organization also includes its effect on quality of care and clinical outcomes. Quality indicators are more difficult to quantify because they typically cannot be associated with a financial metric. However, because the very basis of case management is founded on the notion that it bridges the clinical and financial worlds, it is imperative that the quality outcomes be given just as much attention as the financial outcomes. *(For more on these metrics, see story, p. 58.)*

• Service outcomes.

Case managers might consider placing patient satisfaction under the category of service or quality. In either case, it is an important metric. Also included under service should be physician and staff satisfaction. Issues to consider when measuring patient, staff or physician satisfaction include:

— the measurement tool and specific questions selected;

— measurement frequency;

— which staff you want to measure for satisfaction;

— which case management roles and functions affect satisfaction.

• Regulatory compliance.

Monitoring the departmental compliance with regulatory indicators is important as a measure of the compliance of the department but should be kept separately as an indicator. Examples might include:

— providing patients with "choice" lists for home care and nursing homes;

— appropriately documenting discharge planning assessments;

— using Condition Code 44;

— appropriately documenting patient discharge disposition.

• Productivity.

Productivity measures are indicators of the volume of work performed by the department. Although they might give an indication of the amount and complexity of the work, these numbers alone don't demonstrate the organizational outcomes, but rather the volume of the work itself. If monitored, they should be used for the internal evaluation of the department and of the case management staff and should be used within the department only. The department leaders might find, however, that they need to evaluate the work performance of individuals in the department to demonstrate the need for more staff members. In these circumstances, productivity measures are appropriate.

Case management leaders might consider using some of the productivity measures to evaluate staff member's performance with their annual performance review. Examples of staff productivity measures include:

— caseloads;

— number of patients discharges with services by type of service;

— number of case management assessments completed;
— number of case management assessments completed within 24 hours of admission;
— number of insurance reviews completed;
— number of interventions on avoidable day issues;
— avoidable days capture rate. ■

Selecting goals for your department

By **Toni Cesta**, PhD, RN, FAAN
Senior Vice President
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Brooklyn, NY

Every case management department should have three important documents in its policy manual. These are a vision statement, a mission statement, and departmental goals. These documents should be reviewed annually and updated as needed.

When writing the department's goals, consider the following:

• What are the hospital's goals and strategic plan?
• Are the case management department's goals aligned with the hospital's goals?
• Are the goals clearly defined?
• Are the goals measurable?
• Are the goals and outcome measures within the control of the case management department?
• Are the outcomes meaningful to the department and to the hospital?
• Do the goals clearly demonstrate the impact of the department on the financial and clinical outcomes of the hospital? ■

Measuring LOS, costs, and denials

By **Toni Cesta**, PhD, RN, FAAN
Senior Vice President
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Brooklyn, NY

Examples of financial outcomes measures include length of stay (LOS), cost per day, cost per case, and third party payer denials.

The most common indicator used by case management departments, length of stay is a sensitive indicator affected by virtually every department and discipline in the hospital.

A diverse indicator, it can be reported in an endless number of ways. Consider reporting length of stay broadly and then drill down as needed.

Consider reporting your length of stay by payer as different patient groups will have differing length of stay projections. For example, the Medicare patient might have a different expected length of stay than the Medicaid or commercial managed care patient. Medicare patients typically present with complexities such as comorbidities, financial or social issues, as well as their age, which might contribute to a longer overall length of stay. The better you understand the sub-sets of patients you are dealing with, the more likely you will be able to apply performance improvement techniques to reduce their length of stay.

Other metrics include:

• **Cost per day and cost per case.**

To evaluate cost per day and cost per case, the hospital must have a cost-accounting system. Many hospitals have purchased software programs that allow them to differentiate between direct and indirect costs of care.

For case management's purposes, we are interested in direct costs of care. Direct costs are those resources that are used to care for a specific patient, such as medications, pharmaceuticals, and laboratory costs. Cost-accounting systems allow the user to calculate the actual dollar amount of resources spent on specific patients. Indirect costs are those associated with the running and maintenance of the hospital and include such items as heating, lighting, insurance, and other similar costs.

When evaluating your hospital's performance as it relates to the direct care of the patients, the direct costs can be compared to the expected direct costs for a specific patient type. For example, the hospital should know prospectively the cost of caring for a total knee replacement patient and can look at those cases in which the direct costs exceed those expected for possible performance improvement or quality improvement opportunities. For example, were the excess costs due to clinical complications, physician practice, throughput delays, or discharge planning issues?

• **Third–party payer denials.**

Third-party payer denials are a commonly used financial metric. Denials can be related to actual dollars lost and are easily measured and tracked.

The department of case management should keep track of initial denials received as well as those lost or recovered after appeal. Trending of the data can demonstrate significant financial returns to the hospital. The data should be routinely reconciled against the data being reported by the finance department to ensure that both departments are reporting in similar fashion.

To monitor denial data, the case management department must keep accurate data and enter that data into a database in a timely fashion. The data should be audited periodically to ensure that it is accurate. The denials then can be correlated to actual dollars based on the hospital's specific reimbursement rates.

The items below show the variety of ways in which denials can be aggregated and monitored:

- measure reductions in initial denials — organizational;
- measure reductions in final denials — organizational;
- measure percent reductions on each of the above over time — organizational;
- determine denial reversal rate — organizational;
- measure effect of physician advisor — departmental;
- aggregate by physician/payer.

Other financial metrics to consider include: observation days, average hours in observation, percent of patients admitted after observation, inpatient/outpatient conversion rates, and avoidable days versus excess days. ■

Measure these metrics related to quality

By **Toni Cesta,** PhD, RN, FAAN
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Quality outcome metrics, compiled for the entire organization, include readmissions, discharge/disposition delays, delays in service/turnaround time, patient satisfaction, and inappropriate admissions.

A readmission, under the Medicare definition, occurs when a patient is readmitted to any acute care hospital within 30 days of the prior discharge. As discussed in last month's article on reducing readmissions, a formal readmission reduction program is integral to any case management department.

In addition to looking at 30-day readmits, the department also might want to monitor readmissions same day, within 24 hours, within one week, or within 14 days. Readmissions within shorter timeframes might indicate an issue with the discharge plan. By organizing readmissions into subsets, the case managers can evaluate their discharge planning process and outcomes to determine whether corrective action is warranted.

Other metrics include:

- **Discharge and disposition delays.**

Discharge and disposition delays are issues associated with the department's inability to transition the patient out of the hospital in a timely manner. These issues might have to do with the availability of services in the community, family issues, financial problems, or physician issues. They also might be related to the performance of the individual discharge planner. To evaluate the performance of the case management department in discharge planning, the department should consider monitoring and analyzing these issues on a regular basis.

Delays in service turn-around time should be tracked and trended. High volume delays should be reported to the appropriate department. Examples might include turn-around time for completion of tests, treatments, procedures, consults, as well as the reporting of same.

- **Patient satisfaction.**

Patient satisfaction questions should be critically evaluated by the case management department to ensure that they have value in determining the effectiveness of the staff and the department. If none of the available questions relate to the work of the department, see if you might be able to add specific questions that might be more relevant. Patient satisfaction is affected by so many departments and disciplines that it is critical that the questions used are relevant and have meaning.

- **Inappropriate admissions.**

Inappropriate admissions have an effect on quality, patient flow, length of stay, and patient safety. Patients who do not need to be in the hospital should not be exposed to the acute care setting unnecessarily. The case management department can monitor these inappropriate admissions through its denial database by tracking the denials for "medical necessity on admission." The ED case manager can play an important role in evaluating patients during the pre-admission process and provide alternatives to admission when appropriate. ■

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Beckman, RN, ACM, CPHQ CHAM, corporate director of care management at the not-for-profit health system. The system includes a 442-bed tertiary care regional referral center and a 192-bed community acute care hospital.

After they are hired, the new employees go through a two-day hospital orientation and five weeks of training with a dedicated preceptor in the care management department. They must pass a series of competencies and tests before they can work on their own.

"It's rare to find an experienced care manager," Beckman says. "It's necessary to develop an excellent training program for the right person for the department. If they come from another hospital, they may have performed the same tasks but in a different way, so they still have five weeks of orientation."

When a care management job becomes vacant, she posts the job internally and on the hospital's web site and CareerBuilder.com. While Beckman prefers to hire experienced case managers, that type of hiring happens only about 10% of the time. Most of her new hires are floor nurses who want to become care managers. "It's rare to find care managers who move from hospital to hospital," Beckman says. "What I find are people who want to become care managers. If I can find the right people, I'm willing to make an investment and train them."

She gives preference to nurses with a BSN degrees and five years of clinical nursing experience, preferably in the intensive care unit or emergency department. "Nurses with backgrounds in the ICU or ED understand more of the big picture," Beckman says. "I always look for people who can multi-task, who have good computer skills and good interpersonal skills."

She reviews all the applications and schedules a screening interview with the candidates who meet her criteria. Beckman selects two or three good candidates to move on to the peer interview process.

A team of care managers trained in peer interviewing conduct the final interview, score the candidates based on their responses, and make the final selection. They ask questions they developed to give them an idea of the candidates' communication skills, adaptability, team work, ability to exercise initiative, conflict management skills, and engagement ability. For example, to judge communication skills, the peer interviewers ask the candidate to describe a time when they had to sell an idea or a plan to a patient and family. Under the category of conflict management, they ask the candidates to talk about a how they overcame a difficult experience with a physician, a patient, or a family member.

Each member of the peer interview team scores the candidates on all the questions. Whoever scores the highest is offered the job. "The team interviews the candidates and selects someone they can work with and who will fit into the department," Beckman says.

SOURCE

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EXECUTIVE SUMMARY

Candidates for a care management position at Jewish Hospital and St. Mary's Healthcare, a Louisville, KY, health system are screened by the care management director and chosen after going through an extensive interview with a panel of care managers trained in peer interviewing.
New case managers undergo five weeks of training with a dedicated preceptor and have lengthy meetings with other disciplines and ancillary departments.
The hospital requires case managers to pass a comprehensive competency test before working independently.

New CMs receive class, preceptor education

Learning to manage cases on their own

New case managers at Jewish Hospital and St. Mary's Healthcare in Louisville, KY, go through a rigorous training process that includes classroom education, meetings with representatives of departments that work with case management, and five weeks of training with a preceptor.

The care management department's preceptor is an accredited case manager who has been trained as a preceptor. When she is training a new employee, her only responsibility is to be a preceptor. When she is not training, she is a case manager on the floor.

"It is very important to have dedicated preceptors. It's not effective to bring in new people and have them trained by multiple individuals. By having one preceptor do all the training, the teaching is

consistent," says **Bev Beckman**, RN, ACM, CPHQ CHAM, corporate director of care management at the not-for-profit health system that includes a 442-bed tertiary care regional referral center and a 192-bed community acute care hospital.

During the first week, the care manager and preceptor go over the care management process, the daily routine on the nursing unit, the department's walking rounds, discharge planning, the department's computer system, the care manager's role in core measures, and the denial management process.

The preceptor shows the new employee how to perform an initial assessment and review each day for medical necessity, use InterQual and Milliman, determine patient status, work with the physician on documentation, interact with the company that performs second level physician review, evaluate and screen patients, and make a referral and follow through. "Our goal is to teach the practice of care management," Beckman says. "It takes us years to learn to be nurses, and it also takes a certain amount of time to become a competent care manager. We teach them the standards of practice and how to execute them within our hospital system. The teaching is the same for everybody."

The department has developed its own training manual and has a shared drive on the computer system with all the forms and procedures the case managers use. "Care managers should never have a question about what we do because all our practices are on the shared drive," Beckman says.

As part of orientation, the new care managers meet for two to three hours with a social worker, the rehabilitation coordination, and a financial counselor. The new care managers spend time observing in the resource center with LPN payer specialists who provide remote denials management and utilization review services for the two acute care hospitals.

Beckman spends about three hours with the employee. "I talk to them about our philosophy and the practice of case management," she says. "When I meet them, I talk about our care management model; our mission, goals, and objectives; and how we are integrated with the organization's philosophical framework. I go over the job description and role, annual performance evaluation, work schedule procedures, time and attendance, vacations, and breaks."

The new employees spend a day in the classroom for computer education and begin working cases in increments. The first week, after the preceptor has covered some of the details on how the department works, the new care manager is assigned three to five cases. The number of cases increase to up to seven during the second week, up to 15 the third week, and up to 20 cases on week four.

"On week five, we put them on the unit where they're going to work," Beckman says. "The preceptor is available but lets the care manager work independently. The preceptor is there to shadow the care manager and to be available if any questions arise."

Before they can work independently, new care managers have to demonstrate competency in all tasks and pass all tests. The department has developed a comprehensive competency checkoff list for all tasks that for which care managers have responsibility. Then they take a 38-question online competency test that includes the full scope of everything they have learned and an online InterQual test where they are asked to review case scenarios and determine patient status and level of care. They must complete an online module on the Hospital-Issues Notice of Non-coverage (HINN) and another module during which they demonstrate that they can identify the necessity for and complete a Condition Code 44 document.

"All our care managers have a toolkit that includes a laptop computer with access to our share drive, an orientation guide, and our training manual," Beckman says. "They are linked to the preceptor forever and are encouraged to ask anyone on the team for assistance." ■

Transition initiated during pre-admit screen

Educate, plan discharge before surgery

At New England Baptist Hospital, in Boston, social workers meet most patients at the preadmission screening appointment. A case manager follows up with at risk patients after discharge to make sure they have a smooth transition home.

It's all part of the 162-bed orthopedic center for excellence's Legendary Service initiative, launched in 2005 to provider a higher level of service to patients, visitors, and each other. The hospital's average patient population is 90% orthopedic, about 5% medical, and 5% general surgery. The hospital performs almost 5,000 total joint replacements and 1,400 spinal surgeries each year.

The case management department has 7.5 FTE RN case managers and three social workers, all

of whom are unit-based. Case managers work 10 hour days, four days a week. All of the case managers who are eligible have achieved case management certification.

"We find that eight hours isn't enough for the case managers to complete everything," says **Eileen Galvin**, RN, ONC, CCM, director of case management for the medical and surgical facility in the Mission Hill area of Boston. "The longer shifts and four-day workweeks have done a lot for staff retention and satisfaction."

Social workers work five eight-hour days, with one FTE assigned to the preadmission screening unit. They work as a team with the case managers on the unit and are careful to respect each other's role and avoid duplicating services, Galvin says.

Most patients are having scheduled surgery and participate in a multidisciplinary pre-admission screening where they meet all members of the treatment team. During the pre-admission screening, a social worker meets with the patient and family to educate them about case management and how the case management team can help patients during their hospitalization. The team gives patients a brochure describing case management services along with a case manager's phone number they can call if they have questions before surgery.

The social workers assess each patient's home situation, discuss their choices in case they need to go to a post-discharge facility, and educate them about what they can do in advance to prepare for the post-surgical period, such as preparing meals and freezing them. Patients who are having total hip replacement surgery, total knee replacement surgery, or spinal surgery also attend a comprehensive educational class before surgery.

"The goals of both of the pre-surgical visits are better care through education. We want our patients to be better prepared and be informed of their choices," Galvin says. The social workers educate the patients on how to review their insurance benefits and find out what is covered. Some

EXECUTIVE SUMMARY

At New England Baptist Hospital, in Boston, a hospital specializing in orthopedic surgery, care coordination begins at the pre-admission screening and continues after discharge.

- Social workers get a head start on discharge planning before the patient is admitted.
- The treatment team uses a goal directed pathway individualized to each patient's needs.
- Case managers call at-risk patients after discharge.

CNE questions

13. According to Toni Cesta RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center and Beverly Cunningham, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital, what is the minimum orientation period for new employees in the case management department?
A. Two weeks
B. Four weeks
C. Five weeks
D. Six weeks

14. How long is the preceptor training for case managers at Jewish Hospital and St. Mary's Healthcare?
A. Four weeks
B. Five weeks
C. Six weeks
D. Three weeks

15. At New England Baptist Hospital, case managers call all high-risk patients after discharge to make sure they have a smooth transition home. How long do they wait to call?
A. 24 hours
B. 48 hours
C. 72 hours
D. Five days

16. Is the following statement true or false? At City of Hope National Medical Center, utilization review duties are assigned to a separate utilization review staff instead of case managers.
A. True
B. False

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

CNE instructions

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

don't have rehab or home care benefits and if they know that before the surgery, they can make better choices about post-acute care, she adds.

After surgery, the treatment team uses a goal-directed pathway developed by the case management team and the clinical team. The pathway clearly defines the goals patients must meet before transitioning to home and is individualized for each patient's needs.

The physical therapy staff writes the projected day of discharge and the goals on a white board in the patient's room and updates it daily, making the family aware of when they need to have everything in place for the patient to go home. At discharge, patients receive an envelope with all of their paperwork, including prescriptions, discharge plan, and post-surgical instructions, along with telephone numbers for the home care agency and the case manager.

Collecting all the paperwork in one place ensures a smooth transition to the next level of care because the home health nurses or the staff at the skilled nursing or rehab facility has everything they need to continue the patient care, Galvin says.

Case managers call all high-risk patients 24 hours after discharge to ensure that they have a smooth transition to home. They use a standard set of questions designed to make sure all that needed equipment has arrived, the home health agency has called, and the patients have filled their prescriptions. They give patients a telephone number to call if there are questions. High risk patients include those going home with intensive services, such as IV antibiotics, those who live alone with a limited support system, or those that the case manager instinctively feels they should check on.

"All patients have a case manager's phone number and can call if they are having problems," Galvin says. "The case manager knows where to transfer the call or they make sure that the patient gets a follow-up call with the appropriate person."

In addition, case managers make four random telephone calls a month to patients, usually two to three weeks after discharge to find out how they are doing, if their discharge needs were met, and if there were any problems. "We go over their treatment plan, their progress, and make sure everything went well," Galvin says. "We discuss any concerns or problems with the appropriate department heads and staff."

The case managers also call patients who were discharged to a post-acute facility after they get home to find out how the post-acute stay went. "We use the information we elicit from the patients who had a post acute stay to make sure we feel comfortable referring patients to certain facilities." Galvin says.

If the patients report problems, the hospital works with the facility to correct them. "We've found that some home health agencies don't have the staff to see the patient as quickly as we expect," Galvin says. "Instead of within 24 hours of discharge, sometimes the visiting nurse may not be able to visit for two to three days. In these cases, we make changes in our referrals." ■

Cancer hospital assigns UR to dedicated nurses

As part of its efforts to increase patient satisfaction and reduce length of stay, City of Hope reorganized its case management department, assigning case managers by unit and assigning all utilization review activities to a dedicated staff of registered nurses.

"Our hospital is a National Cancer Institute-designated Comprehensive Cancer Center, which means that many of our patients require specialized care from a number of clinicians," says **Mary Scott**, RN, MS, director for case management and clinical practice education at the Duarte, CA, facility. "By reorganizing, we wanted to become more efficient but continue to provide patients with everything they need related to care progression during the course of treatment."

Patients at City of Hope have an average length of stay (LOS) of 9.5 days because their care needs are so complicated, Scott says. As part of its efforts to reduce LOS, the hospital administration brought in a consultant to help to help determine how to align the department to optimize the case managers' time and provide optimum patient care.

Before the redesign, case managers were aligned by physician and physician group. Now they are assigned by units and receive specialized training on coordinating care for patients on their unit. There are case managers on each of the two bone marrow transplant units and a separate case manager for pediatric patients. The other case managers are assigned to medical oncology and surgical oncology units. *(For details on the case managers' day-to-day activities, see related article on p. 64.)* "Having the case managers assigned to the point-of-care provides better continuity of care," Scott says.

The redesign task force decided to completely

EXECUTIVE SUMMARY

City of Hope in Duarte, CA, reorganized its case management department to give case managers more time to spend coordinating care for severely ill cancer patients.
- CMs are aligned by unit, not physician
- Utilization review responsibilities are handled by a dedicated team of nurses
- CMs and physicians have goal-of-care conferences to discuss long-stay patients
- Clinical nurse specialists and case managers collaborate on patient care

remove utilization review (UR) responsibilities from case managers and to assign them to a focused UR staff. The nurses who conduct UR report to the quality improvement team and case management leadership.

The hospital chose to continue to use RNs for utilization review because the care of cancer patients often is extremely complicated, Scott says. They work with the physician advisor and the hospital's off-site physician advisor service when questions about medical necessity arise. "It takes someone with a lot of clinical knowledge to review the medical records of our patients and to make the case for medical necessity," she says.

Coders are assigned to each hospital unit and perform concurrent coding. They interact with the case managers frequently, and plans call for them to round with the physicians, Scott says. "The utilization review piece of the reorganization has gone quite well," she says. "Our denial rates are very low, and our denial days are low."

Assigning UR duties to other clinicians allows case managers to spend more time at the bedside with patients and families and to be more proactive in planning for discharge, Scott says. Patients often have multiple admissions, multiple treatment processes, including clinical trials or one-day procedures. Many spend time in the ICU.

"We see patients in many sets of circumstances," Scott says. "Once they come into the system, they are likely to stay in our system and receive services over a long time. The case managers follow them as they transition from one level of care to another."

As part of their efforts to reduce LOS, hospital administrators are reviewing the files of patients whose stay was two times greater than the geometric mean length of stay and looking at roadblocks to discharge and ways to decrease the stay.

The case managers have goals-of-care conferences with the treating physicians when patients have a length of stay that is longer than expected. "We look at the treatment plan and what we need to do to get the patient ready for discharge," Scott says. "Most of the time when patients have a long length of stay, it's because it wouldn't be safe for them to go home and it takes time to find a post-acute placement for them."

As more California residents have become eligible in recent years for California's public health insurance program, the difficulty in post-acute placements has increased because a lot of providers won't take MediCal patients, she adds. Medication management often impacts length of stay and readmissions, Scott adds. "We routinely send people home on 20 or more medications, and it takes a while to get the medication adjusted in the hospital," she says. "Then when they get home, it's difficult to manage."

The case managers are re-evaluating all readmissions to determine why the patient came back and what could have been doing to eliminate the readmission. "We want to know if the patient was sent home too soon or is having symptom management issues we didn't address, if the readmission is because of disease progression, or if they aren't able to manage their pain or other symptoms at home," Scott says.

The team has determined that many patients are readmitted because of medication management issues at home. Other times, they didn't tell the staff how much pain they were in because they were so eager to go home. Then they come back to the hospital because they can't control their pain, Scott says. "We're looking at the cause and the nature of readmissions and what we can do to prevent them," she says. "It's traumatic for cancer patients to come back to the hospital because they would much rather be at home with family." ■

COMING IN FUTURE MONTHS

- Why you should know about the business end of healthcare
- Collaborating with other disciplines for better patient care
- More tips on preparing for the RAC audits
- How your peers are preventing readmissions

The cancer challenge: Coordinate care

At City of Hope National in Duarte, CA, case managers (CMs) collaborate with clinical nurse specialists to manage the care of complex cancer patients.

The hospital has 177 inpatient beds and typically is at about 75% capacity. About 40% of patients are involved in clinical trials. Case managers typically have a case load of 15 to 18 patients.

The CMs round each day with the clinical nurse specialists on the unit and review the charts of all new patients. The clinicians look at the patient's disease process, complications, symptom management, and skin issues. They make sure that the documentation in the medical record has captured all the patient's symptoms. The case managers also attend multidisciplinary rounds led by the physicians and work with theclinical nurse specialists to set goals of care for the day. They include other clinical staff, patients, and family members in the discussion.

The case managers assess patients for the reason of admission and work with the utilization review nurses to make sure the patient continues to meet medical necessity criteria. They assess the patient's psycho-social needs, home situation, and short-term and long-term treatment plans. They also make sure the patient is moving through the hospital continuum to discharge. They hold goals-of-care conferences with the unit staff, the ancillary staff, and the family. Case managers also work with patients and family members to help them make decision for palliative care and end of life. ■

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.