HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

March 2012: Vol. 20, No. 3
Pages 33-48

IN THIS ISSUE

Financial Disclosure:
Executive Editor **Joy Dickinson**, Managing Editor **Felicia Willis**, Editor **Mary Booth Thomas**, and Consulting Editor **Toni Cesta**, PhD, RN, FAAN, consulting editor of *Hospital Case Management* and author of *Case Management Insider*, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. **Donna Zazworsky**, RN, MS, CCM, FAAN, serves as peer reviewer for *Case Management Insider*. She has no relevant financial disclosures.

AHC Media

Demonstrate your value to retain, add case management staff

Without data, administrators may have unrealistic expectations

With increasing scrutiny on medical necessity and cuts in reimbursement, along with a growing emphasis on care coordination and transitions in care, case management's position as a major player in the hospital should be assured. But that's not always the case.

"Some hospitals are eliminating case management positions as a cost-cutting measure, at a time when case management has never been more important," says **Kathleen Miodonski**, RN, BSN, CMAC, manager for The Camden Group, a national healthcare consulting firm with headquarters in Los Angeles. "Why this happens is ultimately due to the hospital leadership's lack of understanding of the value of case management in the revenue cycle and the role case managers have in supporting the organization's goals."

In many instances, case management leadership hasn't effectively marketed the department to the hospital's senior leadership, she says. "Even though case managers are doing a great job, nobody knows it. If senior management doesn't understand what case managers do, they may have unrealistic expectations of the department, or think that they can cut staff and save money," she says.

Miodonski cautions that case managers must keep in mind that, like everyone else in healthcare or other professions, they are not

EXECUTIVE SUMMARY:

Some hospitals are eliminating case management positions as a budget-cutting initiative, in part because the hospital leadership doesn't understand the value case management brings to the table.

- Market your department to senior management.
- Describe the case management role and contribution to the revenue cycle.
- Present data that is relevant to the hospital administration.
- Create reports that are short and to the point.

empirically entitled to their jobs. "In today's economic climate, people have to demonstrate their value to the organization every day. Case management leaders should make sure that the department leader to whom the department reports, understands what case managers do and their contribution. Otherwise, they can't defend the department when budget cutting time comes around," she says.

When Miodonski worked with a hospital where the case management department reported to the chief medical officer, she challenged him to shadow a case manager for a day to get an idea of what they do.

"It was a very eye-opening experience for him. He stopped after a couple of hours because he was exhausted. He told me he didn't know how the case managers get through the day," she says. That strategy won't work with every administrator who may not have time to follow a case manager. Instead, case management leaders need to look for other ways to educate the administration on the role of case managers and their contributions to the hospital.

Case management directors can't just go to the administration and ask for more staff, 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. They need to make a case for retaining staff or adding staff by showing the value that case managers bring to the organization. To demonstrate your value, track what you do every day, and create reports that demonstrate the impact case management has on the hospital's financial health, she says. *(For tips on creating reports, see related article on p. 35.)*

You may need to explain the roles of your department before you make the case for more staff. In addition to giving the administration a list of roles, provide specific and detailed definitions and outline the functions your department performs for those roles, Cesta advises.

Miodonski points out that case managers help the hospital comply with payer requirements contracts, such as conducting pre-certification and continued stay reviews within a certain time span. They assist physicians in identifying the correct patient status and level of care. They have skills in writing appeals to capture revenue that otherwise would be lost, she says. "All of this prevents denials and keeps the revenue cycle moving," she says.

In addition to avoiding denials and moving patients through the continuum, case managers make significant contributions to the hospital's utilization review committee and in helping the

Hospital Case Management™ (ISSN# 1087-0652), including Critical Path Network™, is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Case Management™, P.O. Box 105109, Atlanta, GA 30348.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 Mon.-Thurs.; 8:30-4:30 Fri. EST. E-mail: customerservice@ahcmedia.com. Web site: www.ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $78 each. (GST registration number R128870672.)

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 18 clock hours.

The target audience for Hospital Case Management™ is hospital-based case managers. This activity is valid 24 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Mary Booth Thomas**, (marybootht@aol.com).

Executive Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).

Managing Editor: **Felicia Willis.**

Production Editor: **Kristen Ramsey.**

Editorial Questions

For questions or comments, call Joy Dickinson at (229) 551-9195.

hospital comply with accreditation and regulatory requirements, she says.

Miodonski advises that case management directors take every opportunity to present case management outcomes at meetings, particularly where other departments and senior leadership are involved, she says. "The responsibility of case management leadership is to help the hospital's senior leadership connect the dots from case management to the revenue cycle, regulatory and accreditation compliance," she says.

Case managers also should be aware of the kind of threats to the hospital's bottom line that the Medicare Recovery Auditor Contractor (RAC) reviews, and ever-changing payer regulations pose. Then they can use that information to demonstrate the impact that case managers have on preventing denials and ensuring that the documentation is in place for a successful appeal.

"Case management leaders should stay informed about healthcare reform and what the potential impact may be to the organization, and use that data to develop case management strategies to address the impact. Then they should be able to articulate case management's contribution to the senior leadership team, Miodonski says.

It's not uncommon for case management leaders to practice the same way for years and not take other issues, such as healthcare reform or the healthcare market into consideration.

"They need to be aware of what is going on, what new legislation and payer regulations are being proposed, and what the impact is likely to be, and plan accordingly," Miodonski says.

SOURCES

For more information, contact:

• **Gerri Birg**, RN, MSN, Managing Director, Huron Healthcare, Chicago. E-mail: gbirg@huronconsultinggroup.com.

• **Toni Cesta**, RN, PhD, FAAN, Senior Vice President, Operational Efficiency and Capacity Management at Lutheran Medical Center, Brooklyn, NY. E-mail: tcesta@lmcmc.com.

• **Beverly Cunningham**, RN, MS, Vice President, Clinical Performance Improvement, Medical City Dallas Hospital. E-mail: Beverly.Cunningham@hcahealthcare.com.

• **Kathleen Miodonski**, RN, BSN, CMAC, Manager for The Camden Group, Los Angeles. E-mail: kmiodonski@thecamdengroup.com. ■

Keep reports short and to the point

Gear data to your audience

When it comes to making a point with a hospital administrator or a physician, you have five seconds to get their attention and five minutes to keep it, says **Gerri Birg**, RN, MSN, managing director Huron Healthcare, a healthcare consulting firm with headquarters in Chicago.

This means that case management reports should be in a simple and concise format that busy administrators can understand very quickly, she says.

Beverly Cunningham, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital, and partner and consultant in Case Management Concepts, Dallas, agrees: "Case management directors should present senior staff with succinct and relevant information. A presentation should be like sound bites — brief and to the point," she adds.

Birg advocates gearing your reports to the group to whom you are speaking. For instance, physician groups are more interested in patient outcomes. Health information management's major concern is compliance, and the chief financial officer's interest is revenue.

"The administration wants quality data but they want to see the financials as well. Too often they see case management as a place where the hospital is spending money rather than saving it," she says.

Cunningham adds that having a business plan for case management makes the difference between a department that succeeds and one that does not. Look at your hospital's goals and determine what case management contributes to meeting those goals, Cunningham suggests.

"Take a look at where the hospital is headed and show them what case managers can do to take them there. Case management directors should be creating a business plan every year that is aligned with the goals of the hospitals, Cunningham says.

If you don't know how to create a business plan, look for help from the strategic development office or the chief financial officer, she says.

Cunningham recommends that case manage-

ment reports be related to the key indicators being measured by the hospital and should be aligned with the hospital's goals. For instance, length of stay may not be an issue, but maybe the emergency room frequently is on diversion. Showing that case managers have been able to free up beds and improve patient flow will be important to administration.

Or you can show how the case managers determined that some physicians are overusing ancillary services, which slows down the services for other patients and keeps them in the hospital longer, creating patient flow problems that lead to emergency department diversion.

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, LLC, recommends gearing your presentation to the issues that are most meaningful to your hospital administration.

"We use a case management report card when we talk to the administration but we are tracking much more than dollars these days because of all the changes brought about by healthcare reform. Quality is now attached to reimbursement so we have to demonstrate that as well," Cesta says.

When you start to develop your report, determine what measures can be used to demonstrate the effectiveness of case management. Categories of measures include process metrics, such as productivity and regulatory compliance, and clinical, financial, and service outcomes metrics.

Select quality metrics and financial metrics to track since case management impacts both. Whenever possible, include the dollar impact associated with the case management interventions, Cesta says.

Kathleen Miodonski, RN, BSN, CMAC, manager for The Camden Group, a national healthcare consulting firm with headquarters in Los Angeles says: "Participating in data gathering is the unglamorous part of case management but it's an absolutely essential role. It's time consuming to compile the information and develop reports but it's necessary in order present the information effectively," Miodonski says.

It's hard to describe what case managers do and many hospital administrators have only a vague idea, Miodonski points out. If you're not demonstrating value, you can't expect senior leadership to appreciate the job you're doing, and if you don't track case management metrics, you can't demonstrate value.

Document what case managers do each day and how much time it takes and present the information in a logical form. Have a group of case managers make a list of all the activities they do in a day and keep track of the time each takes. "The first thing leadership is going to ask is if you are working smart. Make sure there are no redundant processes in your department," she says.

Cesta recommends listing all the case management functions, and determining the time frames in which each role and set of functions must be performed. Then perform a time and motion study to measure case management productivity. Start by tallying the average number of reviews done each day by each staff member. Then determine the average length of time it takes to complete each review, Cesta suggests. "It is critical to keep an ongoing case management report card that demonstrates which areas of the organization are impacted by case management roles and functions, and provides a barometer of how the department and organization are doing," Cesta says. ■

Denials drop when CMs, MDs act as a team

Study shows value of collaboration

A study conducted at Good Samaritan Hospital in Dayton, OH, has determined that denial rates are lower when case managers collaborate with physicians to determine patients' admission status.

Marlyn Bledsoe, MHA, RN, a nurse case manager at the 577-bed hospital conducted the study as her master's thesis. For the study, Bledsoe compared the denials at the hospital during a pre-intervention period, which was 15 months when physicians determined the status with no input from case management, with Intervention A, which was the 15-month period when emergency department case managers reviewed every admission for patient status, and Intervention B, which is the current practice: Case managers recommend the status, and physicians have the ultimate decision.

Bledsoe was on a case management team

several years ago that developed a standardized admission process in which every admission, regardless of the access point, was reviewed by a case manager for patient status. "But Medicare changed the game and issued a ruling that physicians, and not case managers need to decide on the status. I looked at this as a good opportunity to conduct a study to investigate whether case managers can have an impact on medical necessity denials," she says.

For the study, Bledsoe analyzed 10 DRGs that had a denial rate of greater than 2%.

The greatest number of denials occurred when physicians were ordering the patient status with no input from case managers and when there was true collaboration between the case manager and the physician (Intervention B), the denial rate went down, the study concluded.

When case managers were determining the status (Intervention A), the denial rate decreased in seven of the 10 DRGs. The three diagnoses where case management intervention had no effect on denials were laparoscopic appendectomies, hypertensive emergencies, and ante partum nausea, vomiting and dehydration. In most cases, the case manager simply did not have enough information in the emergency department to make a medical necessity determination.

"In Intervention B, when case managers communicated with the physicians, there was a further decrease in the denial rate, especially in the area of laparoscopic surgery," Bledsoe says.

Bledsoe cautioned that some data may be different in the future because the two-year period during which the Medicare and Medicaid Recovery Auditors Contractors (RACs) can request records has not expired for cases in the Intervention B group.

EXECUTIVE SUMMARY

A study at Good Samaritan Hospital in Dayton, OH, determined that denial rates are lowest when case managers (CMs) and physicians collaborate on patient status.

- Study analyzed denials during three different arrangements for determining patient status.
- Biggest number of denials occurred when physicians acted alone.
- When CMs set status, denials dropped in 7 of 10 DRGs with 2% or more denials.

Denials went down under Intervention B, denials in every area except one: chest pain. There was close to a 2% denial rate for chest pain in all three intervention areas. When Bledsoe analyzed chest pain denials, she determined that the family practice groups and internal medicine doctors were admitting patients in inpatient status even with the recommendation of observation by case managers.

The study points out the opportunity to work with targeted groups of physicians and educate them on medical necessity criteria and the importance of correct patient status, Bledsoe says. The case management department's next target is to work with family practice groups and internal medicine physicians, she says.

Current literature suggests that there is an increasing trend for observation to be overused, says **Michele L. Marshall**, MS, RN, CNS, NE-BC,CPHQ, senior health services researcher at Good Samaritan Hospital's Center of Outcomes Research and Clinical Effectiveness. "This practice results in lower reimbursement for the services the hospital provides, increase in co-payment amounts for many patients, and it can mean that patients don't meet Medicare's three-day rule for post-acute services. Case managers have an opportunity to educate physicians on the financial impact of incorrect status, and to promote physician collaboration on determining patient status," she says.

Physicians haven't been trained on medical necessity criteria and they are going to treat patients the same regardless of whether they are in inpatient status or receiving observation services. There's a new set of medical criteria rules every year and physicians don't have the time to educate themselves on the changes, she says.

Bledsoe adds: "Case managers have the knowledge base to correctly determine the patient status. We should take the opportunity to look for trends in our denials and educate physicians on the importance of getting the status correct," she says.

SOURCE

For more information contact:

• **Marlyn Bledsoe**, MHA, RN, Nurse Case Manager, Good Samaritan Hospital, Dayton, OH. E-mail: mkbledsoe@GSHDayton.org. ■

Collaboration eliminates sepsis readmissions

Hospital, SNF targeted HF patients

When St. Anthony's Hospital and Pinellas Point Nursing and Rehabilitation, both located in St. Petersburg, FL, collaborated on a project to reduce heart failure readmissions, the team determined that many readmissions were for sepsis. They embarked on a project that eliminated sepsis as a reason for readmission in just six months.

The initiative grew out of a case management-led initiative to analyze readmission rates and develop strategies to reduce the readmissions in advance of the Centers for Medicare and Medicaid Services' plans to penalize hospitals with excessive high readmission rates beginning October 1 of this year. The initial analysis showed that while 11-12% of patients discharged to home were being readmitted within 30 days, the figure rose to 22% among patients being discharged to extended care facilities.

"We saw this as an opportunity to develop a partnership with post-acute providers to better control the situations that lead to readmissions. We decided to zero in on the heart failure population, and translate the lessons to other patient populations. Our first project was to join forces with Pinellas Point Nursing and Rehabilitation and come up with ways we could work together to prevent readmissions," says **Patricia Sizemore**, RN, BSN, MA, vice president of patient nursing for the 395-bed hospital.

EXECUTIVE SUMMARY

St. Anthony's Hospital and Pinellas Point Nursing and Rehabilitation, both in St. Petersburg, FL, collaborated on a project to reduce sepsis readmissions after a study of heart failure patients showed that many were readmitted with sepsis.

- Multidisciplinary committee from both facilities met to develop a sepsis protocol.
- Hospital standardized information, tests, and lab values it sends with transferred patients.
- Nursing facility screens patients for sepsis on every shift for 15 days.
- Team developed a protocol for when patients show signs and symptoms of sepsis.

Case management took the lead in the readmission reduction project, developing risk assessment tools and conducting an analysis to determine what patients were being readmitted, and when and what could be done to reduce the readmissions, says **Julie Losee**, RN, BSN, manager of case management and clinical services.

St. Anthony's team drilled down on data from Pinellas Point readmissions and determined that 56% of heart failure patients being readmitted within 30 days had a diagnosis of sepsis rather than a cardiac diagnosis. The hospital assembled a multidisciplinary committee from St. Anthony's and Pinellas Point, including representatives from social services and case management at both facilities, the nursing and medical directors at the skilled nursing facility, and the skilled nursing liaison.

"We met monthly for several months and looked at what we were doing in the hospital before the patients left and what was happening in the skilled facility. We analyzed the situation and came up with ways we could decrease readmission rates," Losee says.

The team asked the nursing facility representatives what information they needed when patients were transferred, and surveyed physicians who cover the skilled nursing facility to determine what laboratory tests results they needed from patients being admitted, and what order they should be in. Now, the hospital sends the standardized information to the nursing facility during the transfer process, allowing the nursing facility physicians to quickly review it at admission.

The team developed a sepsis screening tool that the nursing facility staff used for every shift for the first 15 days of the skilled nursing admission, to track temperature, heart rate, respiration rate, and any changes in the patient's acute status. The protocol calls for a urine culture and a complete blood count to be completed on the third day of admission, and for the staff to contact the nursing facility medical director and the patient's primary care physician if any part of the screening criteria is positive.

Sizemore points out that physicians who cover skilled nursing facilities traditionally visit patients once a month and don't typically come to the facility for emergencies. When the facility calls the doctor because a patient has a fever, the typical response is to tell the nurse to send the patient to the hospital emergency department for treatment. "We know that hospital admissions

CASE MANAGEMENT INSIDER
Case manager to case manager

The customization of best standards for practice models

More on case management roles, functions, models, and caseloads - Part 4

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

In this month's issue of *Case Management Insider*, we will continue our discussion on case management roles, functions, and models, with more information on today's best practice models. We will explore the advantages of each model and minimum staffing ratios for each.

As we have learned, there might not be one generic model for every organization; however there are basic core roles and functions that should apply to any contemporary case management model. The customization comes after those core roles have been determined, and the functions for each have been established. It is important that each hospital develop the additional roles and/or functions that they might need to meet the organization's outcomes. All of this should be done within the case management standards of practice as we have discussed.

Advantages of each model

The integrated and collaborative models have their own advantages, as well as disadvantages. As we reviewed last month, the disadvantages have to be carefully weighed. In addition to weighing the disadvantages, the advantages also should be weighed and considered. This process should be done using a steering committee to work through the decision-making process. Weigh each advantage and disadvantage against the goals of the particular organization. By involving a committee of individuals from a variety of departments and disciplines, the case management department will have a greater chance of success as the model is rolled out. *(For examples of the integrated model vs. collaborative model, see* Case Management Insider*, February 2012, p. 26.)*

The integrated and the collaborative models build on the inter-relationships of the social worker and nurse case manager to enhance the case management outcomes. Neither model can be successful without strong social work involvement. ■

The importance of adequate staffing

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

No practice model, no matter how carefully designed, will be successful if it is not adequately staffed. Other disciplines and specialties have been able to determine adequate staffing ratios. Bedside nursing, physical therapy, and even house staff, have predetermined caseloads. Case management has lagged in the establishment of such caseloads, and hospitals have been slow to adopt newly established caseloads and budget for them appropriately.

Because of this problem, many case management departments still function with inadequate or severely inadequate caseloads. When this happens, the case management department finds itself in a position of selecting only those functions that must be done, such as clinical reviews or discharge planning. All other activities, such as care coordination

and facilitation, cannot be completed.

When a case management department gets into this kind of position, staff members become dissatisfied with their work, work becomes task-oriented, and ultimately the department no longer performs true case management.

Models are the foundation of the department, and staffing ratios are an important part of any model. The integrated and collaborative practice models are alike in that they require the following to be successful:

- adequate staffing;
- balanced workload;
- skilled staff;
- strong leadership.

The roles, function, and caseloads of any models are interrelated. The more roles and functions you give a case manager or social worker, the fewer patients he or she can handle. This point might seem obvious, but not necessarily so. ■

Issues that impact caseloads

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

Like any model of care delivery, there are a variety of elements that impact on case manager or social worker staff-to-patient ratios. They are as follows:

Model design. The first, and possibly most important, element affecting the need for specific staffing ratios is the model in use. The integrated model requires somewhat different ratios from the collaborative model, and these basic ratios should be carefully considered. However, these ratios should not be considered in isolation of the other elements we will now review.

Roles and functions for each discipline. As the model is selected, the specific roles and functions must be aligned with the selected model. The most common roles assigned to case managers and social workers today include the following:

- patient flow – coordination and facilitation of care;
- utilization and resource management;
- denial management;
- variance tracking;
- transitional and discharge planning;
- quality management;
- psychosocial assessments and interventions.

These roles are foundational to both models and, thus, should be included. More variation can occur when looking at the functions subsumed under each role. By delimiting the number of functions under each role, and/or dividing them between the social worker and case manager, there can be a better balance between the roles and functions for each member of the team.

Patient assignments. The assignment of patients is another key component of the overall model for the case management department. Below are the most common variations in terms of patient assignments:

- unit-based;
- disease-aligned;
- product line;
- physician-aligned;
- high-risk criteria;
- payer;
- complexity;
- length of stay;
- cost;
- clinical;
- hybrid.

The most commonly seen patient assignment structure is unit-based. In this approach, the case managers and social workers are assigned to specific nursing units. Depending on the size of the unit, this structure might mean more than one unit, or part of one unit. The advantages of this approach include the fact that the case manager and social worker become part of the staff on that unit. In addition, they are physically present on the unit thoughtout the day and are available to other team members, particularly the physicians, as they come and go from the unit.

The other approaches should be carefully considered because even if you select a disease-based or physician-aligned approach, you still will need to have some other way to assign patients who are not within those specific disease groups or who are not assigned to those specific physicians or hospitalists.

The physician — or disease-aligned assignments. These allow for continuity of care and, therefore, are appealing to some hospitals. In those circumstances, another approach will need to be used for those patients who fall outside those predetermined assignments. These models become a hybrid, incorporating more than one patient assignment approach.

No one approach is perfect and all need some amount of modification to make them work for the specific hospital. The selection of the patient assignments also will play a part in the determination of the final staffing ratios.

Payer mix. As you consider your staffing ratios, you also should analyze your hospital's payer mix. The percentages of each payer can have an impact on the type and amount of functions the case managers and social workers will need to perform, and they might result in the need to adjust the ratios in some way. For example, if the hospital is in a highly managed care environment, this situation might mean that a greater number of clinical reviews need to be done. The number of clinical reviews will impact on the workload of the nurse case managers.

Conversely, if the hospital has a high percentage of Medicare patients, then this situation might mean more complex and/or time-consuming discharge planning. Ratios might need to be adjusted accordingly.

A high percentage of Medicaid patients might mean that the patient population has a greater number of psychosocial and/or financial issues. High Medicaid hospitals might need a greater proportion of social workers.

Intensity of services provided. Intensity of services has to do with the types of clinical services the hospital provides. Is the hospital a trauma center? Does it perform complex surgeries such as brain, open heart, or transplants? Is the hospital a community or tertiary hospital? Are you typically transferring more patients into or out of the hospital?

The intensity of the services provided can affect the degree of complexity associated with the coordination and facilitation of care performed by the case managers. It will also have an impact on the length of stay.

Complexity of patients served. Patient complexity is a phenomenon specific to every hospital. It can have an affect on the workload of the case manager and social worker. It usually will align with the payer mix, but not always. The patient population might have a higher degree of complexity associated with clinical issues. Conversely, the complexity might lie with complexity of psychosocial issues or financial issues. Each of these elements will have an impact on the role of the case manager and social worker in different ways.

Length of stay. The element of length of stay can have an impact on case management if it is longer or shorter. What does this statement mean? Shorter lengths of stay mean that there is quicker turnover of patients. This length of stay results in more admissions and new assessments for the case manager. It also might mean more referrals to social work. Conversely, longer lengths of stay might be a result of one of two things. It might be because of the severity of illness of the patients treated, or it might be because of complex discharge planning issues. It could also be a combination of these. Because of the variety of issues surrounding length of stay, it should be considered, but not to the same extent as some of the other elements.

Use of technology. The use of case management software can have an impact on the flow of work for the department by eliminating some of the paperwork and helping to make the professional staff more efficient. More case management departments are obtaining specialized case management software. This software includes workflow tools and an electronic way to perform clinical reviews and discharge planning functions. The more automated the department, the more effective the staff can be in performing their routine daily work.

The department always should have some clerical staff to support the work of the professional staff. Faxing, copying, or ordering durable medical equipment should be done by the support staff, also freeing up the professional staff to perform their key functions.

Technology might not ultimately alter the professional staff's ratios, but it will allow the staff to function at a higher level and will increase the likelihood of professional job satisfaction, as well as the achievement of the department's expected outcomes. ■

The process of staffing analysis

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

In this month's *Case Management Insider*, we have reviewed the elements that might impact on the staffing ratios of a case management department. Each element should become part of an analysis process that can be used to customize the ratios to a specific hospital.

The first step is to start with the baseline staffing ratios recommended within each model. They are as follows:

- **Best practice caseloads in the integrated model:**
  - — RN Case Manager
    - o 15 patients/beds on medical floor
    - o 20 patient/beds on surgical floor, ICU, Acute rehabilitation
    - o 20-30 patients/beds on Pediatrics, OB/GYN
  - — Social Worker
    - o 17 patients (active cases)
  - — Emergency Department Case Manager
    - o Depends on patient care needs on any given day
- **Best practice caseloads in the collaborative model**
  - — RN Case Manager
    - o 15-23 patients/beds on medical floor, surgical floor, ICU, Acute Rehabilitation, Pediatrics, OB/GYN
  - — Social Worker
    - o 17 patients (active cases)
  - — Business Specialist
    - o 20-40 patients
  - — Emergency Department Case Manager
    - o Depends on patient care needs on any given day

The most significant difference in the staffing ratios between the two models is that in the Collaborative Model, there is the addition of the business specialist. This difference adds another position to the model and therefore the staffing ratios need to be adjusted accordingly.

Once the model has been selected, the ratios can be determined from the tables above. The next step would be to take the indicators and use them to determine whether the baseline ratios need to be increased or decreased. *(To review the indicators, see article, p. 40.)*

As you proceed through this process, consider the clinical areas you are seeking to staff, as the ratios will need to be further refined to those specific areas as well.

Vacancy coverage

Most case management departments still do not budget for vacancy coverage. Vacancy coverage refers to the additional positions that are needed to cover assignments when staff is off for vacation, holiday, sick days, etc. Some departments might use per diem staff to fill in these gaps. However, "float" staff is more economical and more reliable as they are budgeted positions available to be plugged in wherever needed.

Early case management models could get by without these additional positions as the work was less complex and less time dependent. In today's contemporary environment and with today's best practice models, vacancies cannot be left open. Staff cannot double up on assignments and still get their work accomplished. Like any clinical department, case management should be staffed for these expected absences so that the work can be accomplished and goals can be met.

Moving forward

Adequate staffing means a balanced workload for all staff. Without it, staff will constantly feel as if they are simply "putting out fires" every day. Staffing ratios in case management are probably the least understood, but they are the most important element of any department. If you are having trouble meeting the goals within your department, step back and take a look at your staffing, including the patient ratios, as well as the mix of social workers and nurse case managers. Also look at the other resources in the department, including clerical support staff, technology, and vacancy coverage. Each and every one of these elements can make or break a case management department. Add to that the need to have talented staff and strong leadership and you have the recipe for success!

The staffing ratios should never be considered stagnant, but they should be reviewed annually. Take time to review the elements provided here so that your department can remain a productive and vital part of the care delivery system where you work.

Remember that the ratios for best practice have been tested and retested. Every department needs to have benchmarks that determine how the department should be staffed and the work should be organized. Case management is no different! ■

are disorientating for elderly patients as well as contributing to increased healthcare costs. We are working to diagnosis problems earlier and take steps to treat them in the skilled facility," she says.

The hospital helped the facility develop protocols so that the physicians could implement interventions instead of sending patients back to the emergency department. "When the symptoms were identified earlier, there was an increased cost for antibiotics, but a decrease in the readmission rate," she says.

The hospital is now partnering with another skilled nursing facility in the community on a sepsis prevention protocol. "In this project, we are looking at patients with multiple diagnoses to determine if they are being readmitted because of sepsis," Sizemore says.

Losee says that the case managers at St. Anthony's work with the skilled nursing facility's liaison to ensure a smooth transition. "We make sure that the patient education is complete and that the facility gets all the information it needs to meet the needs of the patients being transferred," she says. ■

ED navigators steer patients to appropriate providers

Lower acuity patients referred to PCPs

Since the Presbyterian Healthcare Services in Albuquerque, NM, started its emergency department navigation program, targeting patients who seek treatment for minor ailments, 11,600 patients have been navigated to other levels of care. Only about 5% of them have returned to the emergency department with non-emergent conditions or illnesses.

"Like many other emergency departments, we were seeing an increase in lower acuity patients. In the past, we continued to add beds and fast track systems to accommodate patients with minor illnesses, knowing clearly it wasn't in the best interest of the patients. The healthcare world is changing and we can no longer continue to provide this kind of care at a very high cost," says **Mark Stern**, MD, MBA, executive medical director of integrated care solutions for Presbyterian Healthcare Services.

Starting with Presbyterian Hospital, the system's flagship facility which experiences 80,000 emergency department visits a year, the health system set up a procedure to screen and evaluate patients with minor illnesses and complaints, and refer them to a primary care provider or urgent care facility for care, when appropriate.

Here's how the program works: All patients who present to the emergency department are assessed by a triage nurse. Those with minor complaints are referred to the hospital's Lean Track area where they are evaluated by a physician or a mid-level provider. If the provider feels that the patient's complaint can be handled safely by a primary care provider within the next 12 to 24 hours, the patient is referred to the emergency department navigator, who can set up an appointment with a primary care provider, or get the patient into an urgent care center.

The navigator makes appointments in real time with a primary care provider or gets them into an urgent care center immediately. If primary care providers are not available within 24 hours, the navigators refer patients to an urgent care center, and schedule a primary care appointment for a more complete evaluation in the future and follow up with patients. The urgent care centers are owned by Presbyterian Healthcare and do not charge patients with no insurance.

"The ultimate goal is to link patients with a primary care provider. We've found that many of these patients don't know how to use the system because nobody sat down and explained it to them. Patients who were in the navigator program were asked why they sought treatment in the emergency department, 93% said they never thought to go anywhere else because their parents and grandparents used the emergency department for primary care," he says.

The navigators explain the benefits of having

EXECUTIVE SUMMARY

At Presbyterian Healthcare Services in Albuquerque, NM, emergency department navigators refer patients with minor ailments to primary care providers or urgent care centers.

- All patients are triaged by nurse in ED.
- Appropriate patients are sent to the hospital's Lean Track area where they are evaluated by a physician or mid-level provider.
- Patients who can safely be treated in 12-24 hours are referred to the navigator, who obtains an appointment for them with a primary care provider or urgent care center.

a relationship with a primary care provider and getting wellness exams. "Many of these patients have insurance, and have a primary care provider assigned to them, but they never thought to call them," Stern says.

The navigators are located at Presbyterian Hospital and are available 24/7. They are not clinicians but are members of the community they serve, who have been chosen for their ability to interact with patients and explain the process to them. They are trained on scheduling and patient complaints. The navigators set patients up with appointments in clinics located near their place of residence, and provide bus tokens to those with transportation problems. The program has been so successful that the hospital's care coordinators use the navigators to set up post-discharge appointments for patients who need a lot of support in making follow-up visits.

Stern points out that an emergency department visit for a minor ailment such as a sore throat costs around $600 while a visit to a primary care physician or urgent care clinic for the same problem costs between $120 and $160. Patients who are treated in the emergency department receive episodic care with no follow up and no continuity in care over time, he points out. In addition studies have shown that patient satisfaction is higher among patients who see a primary care physician or visit an urgent care clinic, he says.

"The goal of the program isn't to improve revenue short-term. The goal is to change long-term behavior. When patients go to the emergency department with a minor complaint, the cost is high and it takes physicians and providers away from real emergencies," he says.

The program has expanded to include Tele-Navigation at two other sites, Presbyterian Kaseman Hospital in Albuquerque and Presbyterian Rust Medical Center, in Rio Rancho, NM. Patients who are appropriate for the navigator program interact with the navigators over a television screen and receive information about their appointments from a fax machine in the room. "Staffing 24/7 at the smaller hospitals is not financially viable. This maximizes the use of the navigators at the main hospital. Patients like the teleconferencing arrangement," Stern says.

SOURCE

For more information, contact:

• **Mark Stern**, MD, MBA, Executive Medical Director, Integrated Care Solutions for Presbyterian Healthcare Services, Albuquerque, NM. E-mail: mstern@phs.org. ■

Readmission project aims to smooth transitions

Hospital collaborates with post-acute providers

As part of its efforts to reduce readmissions, WellStar Health System, based in suburban Atlanta, is meeting with post-acute providers to collaborate on ways to make transitions between levels of care smoother. It is piloting a program in which a transition coach works with heart failure patients in the hospital and follows them for four weeks following discharge. *(For details on the transition coach program, see related article on p. 45.)*

WellStar conducted a systemwide, root cause analysis of readmissions, reviewing charts and interviewing patients to determine the reasons patients were coming back to the hospital, and used the data from the analysis to develop performance improvement initiatives.

"We saw an opportunity to work with post-acute providers to improve transitions of care," says **Kamela Sooknanan**, RN, assistant vice president, medical management for the five-hospital health system.

One of the first steps was to set up a series of community-wide meetings with representatives from skilled nursing facilities, assisted living facilities, home health agencies, hospice agencies, and ambulance companies to discuss improving transitions. The meetings are held every other month and are well-attended. "The post-acute providers say they find them very helpful. These providers rely on the hospitals for patient volume and are interested in working with us to improve patient care. The post-

EXECUTIVE SUMMARY

WellStar Health System in suburban Atlanta partners with post-acute providers to improve transitions in care and reduce readmissions.

- Staff holds regular meeting with post-acute providers.
- Team collaborates on smoothing transitions.
- CMs work with facilities to take back patients after ED visits.
- Transition coach follows patients after discharge.

acute providers understand that consequences to the patients when they are readmitted to the hospital, and are partnering with us very well to prevent unnecessary readmissions," Sooknanan says.

At the meetings, the providers discuss glitches that occur in the transition process and brainstorm on ways to overcome them. "The hospital system was the first to acknowledge that there are issues with transferring patients and we were the first to be transparent. We acknowledged that there was some lack of coordinated care and asked for the post-acute providers' help in fixing it," she says.

Based on input from the post-acute providers, the hospitals in the system have developed a single point-of-contact at each hospital so representatives of the post-acute facilities know who to call if they have questions about a patient. The case management directors of each facility attend the meeting so the facility representatives can put a face with the name.

They have standardized the information the hospital sends with the patient and made sure it's always in the same order. The health system sends a survey to post-acute providers at the time patients are discharged from the hospital, asking for feedback on how the transfer went. "They understand that we want to know when something works and when it doesn't," she says.

The group developed a uniform process of transferring the patient from the hospital to the post-acute facility and is developing a standardized transfer form that all facilities can utilize when they transfer patients back to the hospital. The form includes information about what has been happening with the patient, including medication and vaccinations, so the hospital team won't duplicate something that has already been done. In addition, the form will allow the emergency room physicians and nurses to become very familiar with obtaining the same level of information on all skilled nursing facilities.

The health system's emergency department case managers are working with post-acute providers when patients come back to the hospital to determine if they can be discharged from the emergency department after they are evaluated and treated, and continue the treatment they need in the skilled nursing facility. For instance, if a patient comes back to the hospital with a urinary tract infection, the case managers ask the transferring facility to take the patient back after he or she is assessed and treated by the emergency department physician.

"The post-acute facilities understand what we're doing and anticipate that we may be calling them to take patients back. They're very open and willing to work with us," Sooknanan says. ■

Pilot aims to cut readmissions

Transition coaches follow up after discharge

WellStar Health System, in suburban Atlanta, is piloting a program in which a care transition coach provides oversight to ensure a high quality discharge including extensive education to heart failure patients in the hospital. The coach follows them after discharge to ensure that they are following their treatment plan and keeping their condition under control.

The health system bases its care transition coaching program on Project RED (Re-engineered Discharge) and recommendations from the Agency for Healthcare Research and Quality and the Joint Commission, according to **Kamela Sooknanan**, RN, assistant vice president, medical management for the five-hospital health system. *(For more information on Project RED, see resource, p. 46.)* "Heart failure is a complex disease and has one of the highest readmission rates. We started with heart failure on one unit, and when we know the process is working well, we will roll it out to other diagnoses and other parts of the hospital," she says.

Because of the slow economy, the health system has not been able to add FTEs, requiring the system to be creative in using staff for the program. Instead, one case manager has been trained as a transition coach/discharge advocate. The transition coach makes rounds with the treatment team on the telemetry unit every day. The coach develops a discharge plan for the heart failure patients and focuses on making sure they get the education they need to manage their condition after discharge.

"The care transition coach model is designed to make sure that patients being discharged have the knowledge they need to manage their disease at home. We make sure they understand the disease and their medication and how to take it. We educate them to weigh themselves daily, and recognize symptoms and what to do when they

occur," Sooknanan says.

The coach uses the teach-back method to educate patients on what symptoms to watch for when they go home, and how to manage any red flags. The coach follows the patients for 30 days after discharge, usually calling patients four times during that period, but increasing the frequency when needed. The goal is to call the patients the first time within 24 hours of discharge and make sure they have filled their prescriptions and understand how to take their medication.

Before discharge, the transition coach gives patients a two-sided sheet that includes a 30-day calendar listing their appointments on one side and the Heart Failure Zones, which shows what symptoms and sign to watch for and what to do when they occur.

"We began with heart failure and are now putting together a program for care transition coaches for patients with other complex diseases. The program is appropriate for all chronic illness. The only thing that changes is the education about the specific disease, Sooknanan says.

RESOURCE

For more information on Project RED, visit: http://www.bu.edu/fammed/projectred. ■

AMBULATORY CARE
QUARTERLY

ED appointment-setting helps manage surges

One of the ways busy EDs are attempting to manage long wait times is by enabling patients who don't need immediate care to make an appointment to be seen in the ED one or two hours in advance.

Critics worry that this type of approach will only encourage patients to use the ED inappropriately for problems that should be seen in a primary care setting. However, hospitals using the approach counter that it is helping them to better manage volume. They also say patients usually are much more satisfied with their care when they don't have to sit in the waiting room for hours and don't know when they will be seen.

"What this allows us to do is if we see there are 10 or 20 patients who show up in the triage area, there is a way of essentially taking out all the available appointments for the next five or six hours or until we catch up," explains **Robert Steele**, MD, division chief for adult services in the ED at Loma Linda (CA) University Medical Center. "The beautiful thing about this is that for the first time in my life, we have some control over the patient surge."

Include safeguards

Loma Linda University Medical Center is one of more than 20 hospitals in eight states taking advantage of the online, appointment-setting service offered by InQuickER, a cloud-based, software-as-a-service vendor based in Nashville, TN. Most of these hospitals are charging a fee to patients to use the service, although Steele anticipates that his hospital eventually will drop the $25 fee that it currently charges.

Steele emphasizes that it was the ED physicians who wanted to make the service available, based on feedback they received from neighbors in the community and hospital employees. "We are the big tertiary care trauma center. People want to come see us. They feel we provide a very high quality level of service," he says. "But the problem is that they don't want to wait, and they also don't want to feel that they have been put into a waiting room that is filled with people they don't know and don't recognize. They feel uncomfortable in there, so we took those two variables out."

There are safeguards built into the process so medical problems that need immediate attention get picked up, explains Steele, noting that patients input information about their medical problem when they make their appointments online. "The triage nurse looks at that information, and there are actually times when [he or she] will call up the patient and say that based on the information provided, we think you should come in right away," says Steele. "Our ability to evaluate those patients is only as good as what the patients include, although I experience the same thing when I am face-to-face with a patient. If the patient doesn't give me the information that I need, it is difficult for me to make a good decision."

Sandra Schneider, MD, FACEP, president of the American College of Emergency Physicians

and a professor in the Department of Emergency Medicine at the University of Rochester (NY) School of Medicine and Dentistry, has looked into the practice of appointment-setting in the ED, and believes that it can fulfill a need. "It has to be done right. We don't want patients being told to wait when they shouldn't wait," she says. "If a person has cut himself and needs a few stitches, that is one thing, but the person who is having chest pain shouldn't be waiting, so there is concern that this needs to be done well."

SOURCES/RESOURCE

- **Sandra Schneider**, MD, FACEP, President, American College of Emergency Physicians, and Professor, Department of Emergency Medicine, University of Rochester School of Medicine and Dentistry, Rochester, NY. Phone: (585) 275-8762.
- **Robert Steele**, MD, Division Chief for Adult Services in the ED, Loma Linda University Medical Center, Loma Linda, CA. Phone: (909) 558-4344.
- InQuickER — a cloud-based, software-as-a-service vendor based in Nashville, TN. Phone: (877) 221-7981. Web: www.inquicker.com. ■

PACE aids work flow, frees ED for acute care

With surging demand for emergency care, many hospitals across the country are building larger EDs or expanding existing facilities to make room for more beds. Bucking this trend, however, is Virginia Mason Medical Center (VMMC) in Seattle. The health system has a brand new ED that opened its doors to patients in November 2011; however, at 17 beds, the new ED is actually smaller than the old department. But alongside the new facility is an 18-bed Patient Accelerated Care Environment (PACE), a brand new unit that is designed to help the ED and other areas of the hospital operate more efficiently while also connecting patients with the care they need quickly.

"We downsized our waiting room, as well as our bed capacity in the ED to be able to facilitate the care of just those acute patients who are coming into the ED," explains **Sharon Mow**, MSN, the ED director. Patients who need a few hours of care but do not require admission are quickly moved over to the PACE unit. Also destined for the PACE unit are patients who are in the process of being discharged, as well as the patients who are being prepared for admission. These patients are moved to the PACE unit so that evaluation and treatment can begin immediately before they are transferred to an inpatient bed, adds Mow.

Administrators came up with the concept for PACE when they observed that the needs of patients coming to the ED for care were changing. "Over the last 18 to 24 months, the acuity of patients has continued to rise, really eliminating the need for us to have a fast-track area," says Mow. Instead, what the health system needed was a place to deliver a higher level of care, which is what PACE is equipped to deliver, she says. "We are sending 35% to 40% of our patients over to the PACE unit over the course of the day," adds Mow.

SOURCE

- **Sharon Mow**, MSN, Virginia Mason Medical Center, Seattle. E-mail: Sharon.Mow@vmmc.org. ■

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

- Emergency department case managers as gatekeepers
- Recruiting and retaining staff
- Readmission reduction tips from your peers
- Case management models for today's world

CNE QUESTIONS

1. According to Kathleen Miodonski, RN, BSN, CMAC, manager for The Camden Group, what is the reason some hospitals are cutting case management staff ?
   A. Reimbursement is shrinking due to an increase in insured patients.
   B. Payers are issuing more denials.
   C. Hospital administrators don't recognize the role case managers play in the revenue cycle and supporting the organization's goals.
   D. Hospitals are issuing budget cuts for all departments.

2. According to Marlyn Bledsoe, MHA, RN, a nurse case manager at Good Samaritan Hospital, when physicians and case managers collaborated on patient status, denials dropped in every DRG except one. What was that?
   A. Chest pain
   B. Syncopy
   C. Community-acquired pneumonia
   D. Back pain

3. A multidisciplinary team from St. Anthony's Hospital and Pinellas Point Nursing and Rehabilitation developed a sepsis screening tool that the skilled facility nurses use every shift for how long?
   A. As long as the patient is there
   B. For 15 days
   C. For 30 days
   D. For one week

4. True or False: Emergency department staff in hospitals that are part of Presbyterian Healthcare Services, screen and evaluate patients with minor illnesses and complaints and refer them to a primary care provider or urgent care facility for care when appropriate.
   A. True
   B. False

CNE INSTRUCTIONS

Nurses participate in this continuing education program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■