

HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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Uninsured patients require creative discharge plans

Work with providers, agencies to find placement

With the increase in uninsured and underinsured patients, hospitals face the challenge of finding post-acute care for unfunded or underfunded patients, or keeping them in a bed when they no longer need the acute level of care.

Today's hospitals are treating a lot of patients whose care is expensive and who don't have a lot of funding, particularly for post-acute care, says Karen Zander, RN, MS, CMAC, FAAN, principal and co-owner of The Center for Case Management, a Wellesley, MA-based case management consulting firm. "Case managers need to look at ways for patients to get the care they need after discharge, rather than keeping them in the hospital when they no longer need an acute level of care," she says.

Donna Zazworsky, RN, MS, CCM, FAAN, vice president of community health and continuum care for Carondelet Health Network in Tucson, AZ, points out that patients who don't have insurance often remain in the acute care hospital longer than necessary, because they have no funding for home health or durable medical equipment. Others have extended lengths of stay in an acute care facility because facilities that can provide a lower level of care

EXECUTIVE SUMMARY

Case managers are being challenged to find a discharge destination for patients who are uninsured or underinsured and who need services after hospitalization. These patients often stay in the hospital longer than necessary, at the hospital's expense.

- Case managers should develop a network of community resources that can assist with care for unfunded patients after discharge.
- In some cases, it makes sense for the hospital to pay for a lower level of care rather than keeping patients in acute care beds that could be occupied by paying patients.
- Case managers often are under pressure to move patients through the continuum of care, making it a challenge to create an effective discharge plan for patients with limited financial resources.
- Many unfunded patients are eligible for financial assistance with their healthcare needs, but they aren't aware of it and don't know how to apply.

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won't take patients when they won't be reimbursed for their care. Keeping patients longer than necessary is an expensive proposition for the hospital, as well as exposing patients to potential infections and other risk factors associated with a hospital stay, Zazworsky adds.

Matt Boettcher, LSW, MSW, vice president for continuum of care for Scott and White Healthcare,

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with headquarters in Temple, TX, and consultant for The Center for Case Management adds that case managers are in a position to help move uninsured patients through the continuum of care, but it's a challenge they can't meet alone. "As case management professionals, we have the responsibility to develop a network of community resources and contacts, and to work with community agencies and other providers to help the uninsured find care after discharge," he says. (*For resources for the uninsured and indigent, see box, p. 51.*)

Arrange with local pharmacies to provide assistance for people who need it and set up contracts with skilled nursing facilities, assisted living facilities, and equipment vendors to get post-acute services at a discounted rate.

Keep in mind that patients who are discharged to home with home health services have to have a physician to verify orders with the home care agency and that the home health nurse can call with questions or concerns. This may be a problem with the uninsured since many people without insurance don't have a primary care physician, and may not have seen a doctor for five or 10 years, Boettcher points out. "Case managers need to develop physician resources, whether it's a resident clinic or a clinic that takes indigent patients on a sliding scale, and get the patients connected so they'll have a primary care provider," he says.

Boettcher adds that in many cases, it makes sense for hospitals to pay for patients to go to a lower level of care when they no longer need acute care services, rather than keeping them in the hospital and not being able to fill the beds with paying patients. For instance, if an uninsured patient needs IV antibiotics for four weeks and your hospital has a daily rate of \$2,000, it would cost \$60,000 to keep him in the hospital. On the other hand, it would cost much less for the hospital to pay for a home care agency to administer IV antibiotics.

Paying for post-acute services for people who can't afford them can help with throughput, prevent readmissions, and help hospitals prove that they deserve to continue non-profit status, Boettcher says. Federal law stipulates that hospitals that pay no taxes and make profits have to provide free care as a community benefit in order to maintain their tax-exempt status. He advises that when hospitals are paying to take care of patients at the right level of care, it should be counted as a community benefit and not as bad debt. (*For details on how to develop a plan for paying for post-acute care, see related article on p. 53.*)

"Sometimes it makes good financial sense to pay money not to lose money. It may be a hard pill for the chief financial officer to swallow, unless the case

Healthcare resources for the uninsured and indigent

- The Foundation for Health Coverage Education's website includes detailed coverage information for every state including a short screening questionnaire that identifies personalized options for coverage. www.coverageforall.org. The organization also offers a 24-hour-a-day U.S. Uninsured Help Line at 1-800-234-1317.
- The National Association of Community Health Centers provides information on federally qualified community health centers, funded through federal grants to provide primary and preventative healthcare in medically-underserved areas. www.nachc.com.
- Religious organizations in many communities have operated health centers, clinics and parish nursing programs for the indigent for many years. Others have been established through the federal government's Faith-Based and Community Initiatives. For

more information, visit: www.hhs.gov/fbci.

- The National Association of Rural Health Clinics is an organization of clinics that provide primary care in underserved rural areas and are certified to receive special Medicare and Medicaid reimbursement. www.narhc.org.
- Information on pharmaceutical assistance programs including application forms for assistance from pharmaceutical companies is available at www.needymeds.org.
- The Robert Wood Johnson Foundation's website includes information and statistics about healthcare issues: <http://www.rwjf.org/coverage>
- Other sources for healthcare for the uninsured or indigent include state department of health services, United Way agencies, community agencies, national foundations.

manager paints the scenario that shows the hospital is better off," he says. If the hospital is in the position of paying for a skilled nursing stay, offer the facility at the Medicaid rate. "It works better if you work with facilities that have the same culture and facility as your hospital," he suggests. For instance, non-profit hospitals do better contracting with other non-profit organizations.

Chris Nesheim, RN, MS, CMAC, system director, case management for Lee Memorial Health System with headquarters in Ft Myers, FL, has developed an arrangement with 17 skilled nursing facilities in the area to take indigent patients at a negotiated rate paid by the hospital system. "We negotiate a daily rate on a case-by-case basis. If patients just need bed rest and minimal care, we agree for the hospital to pay the Medicaid rate. If they need a lot of drugs, we find out the cost and take that into account when we negotiate the rate," she says. The hospital system pays the Medicare daily rate for patients who need major wound care or other intensive services.

It's more cost-effective to pay for post-acute care and free up beds, particularly in the winter months when "snow birds" and other vacationers flock to the warm climate, Nesheim says. "In summer, when capacity isn't a huge issue, we may keep them in the hospital until they can safely be discharged," she says. (*For details, see related article on p. 54.*)

Zander points out that as lengths-of-stay are getting shorter and case managers are pressured to move patients out and free up beds, it's often a challenge for overworked case managers to find appropriate dis-

charge options for patients, particularly those without funding. She recommends that hospital case managers start early in the stay to identify their patients' potential healthcare and medication needs, and appropriate resources that are available within the community.

Zazworsky adds that case managers need to look beyond the immediate situation at what is going on in patient's life when he or she leaves the hospital. Find out what kind of support system the patient has at home, financial issues, transportation problems, or other roadblocks to compliance. Case managers should work with social workers in the hospital, and social service agencies in the community to make sure their patients have shelter, food, and other basics. Help your patients get on food stamp programs, energy savings programs, and other types of assistance. "If someone is not living in a safe and secure environment, if they don't have food or are worrying about whether their utilities are going to be cut off, they aren't going to take care of their health," she says.

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Unfunded patients are on the increase

Some may be eligible for benefits

More than 53 million Americans, around 20% of the total population, are uninsured for various reasons, points out **Matt Boettcher**, LSW, MSW, vice president for continuum of care for Scott and White Healthcare, with headquarters in Temple, TX, and consultant for the Center for Case Management, a patient care management consulting firm based in Wellesley, MA.

As health insurance costs have escalated, some employers have reduced coverage for employees, raised deductibles, or stopped providing health insurance altogether. Many people who lost their jobs can't afford the premiums to keep their insurance under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Some people who are uninsured have jobs but they don't make enough to pay for insurance, they work for a small business that is not required to provide insurance and they can't afford private insurance, or they have a pre-existing condition that makes it impossible to find coverage.

Renee Perez, community health outreach coordinator/emergency department navigator at St. Mary's Hospital, part of the Tucson, AZ, Carondelet Health Network, adds that a significant number of uninsured patients seeking care in her emergency department previously qualified for healthcare assistance but lost their eligibility due to cuts in state and federal funding.

Boettcher says that there typically are three categories of uninsured people — those who might become eligible for benefits, those who have used up their benefits and those who will never have benefits. Undocumented immigrants make up the bulk of the third category, he says. (*For more on options for post-acute care for undocumented immigrants, see related article on p. 53.*)

Ankeny Minoux, president of the Foundation for Health Coverage Education, a non-profit organization dedicated to helping the uninsured access health coverage, with headquarters in San Jose, CA, points out that many patients who don't have insurance don't realize that they are eligible for other funding to pay for their healthcare. In fact, when her organization conducted a survey of 28,163 uninsured patients who presented to the emergency department in a large hospital system in California, it found that 80.54% of patients were eligible for public health

coverage programs but didn't know it.

"There are options today for people who are uninsured and who need healthcare but many people are not aware that they can get coverage, and those who qualify have a lot of hurdles to overcome in order to fill out an application to enroll in a funding program," Minoux says.

The Foundation for Health Coverage Education has compiled details and eligibility requirements for hundreds of programs that give financial assistance to the uninsured and underinsured. Patients can log into the organization's website, www.CoverageForAll.org, answer a five-question eligibility quiz, and get a personalized list of health coverage options, including program details and benefits, approximate monthly cost, a list of documents needed for each program, and applications. "This is a great starting point for case managers looking for discharge options and follow-up care for patients, she says.

In addition to the website, the organization operates a 24-hour U.S. Uninsured Help Line, (800-234-1317) with translators available for more than 240 languages. The organization has partnered with the American Cancer Society, the American Heart Association, the American Lung Association, and the American Diabetes Association to help them identify assistance programs.

Donna Zazworsky, RN, MS, CCM, FAAN, vice president of community health and continuum care for Carondelet Health Network in Tucson, AZ, points out that hospitals face the problem of uninsured patients, many with chronic illnesses, are flooding their emergency departments because they can't afford treatment at a primary care provider, or they have no money to fill their prescriptions. Helping patients connect with a primary care provider should be a priority for hospital-based case managers whether they are in the emergency department or the acute care unit, Zazworsky says.

When uninsured patients who come to the emergency department at St. Mary's Hospital are referred to Perez, she logs onto the State of Arizona's electronic application for assistance to screen patients for eligibility for healthcare coverage, cash assistance, nutrition assistance, and other community resources. "Many patients aren't familiar with programs that could assist them and they don't know how to find out if they are eligible," she says. If patients are eligible, she submits the application, and then gives them the list of documents, such as birth certificates and proof of income, they need to prove eligibility. When patients come back to the emergency department and bring Perez their paperwork, she adds that to the application to expedite program eligibility. ■

Challenges for post-acute care

Hospitals have few options for undocumented

When Matt Boettcher, LSW, MSW, made a presentation on healthcare for undocumented immigrants several years ago, his audience included case managers from seven states. When he presented a similar program recently, participants came from 31 states.

The problem of undocumented immigrants has become widespread instead of being confined to the border states, he says. "It's not that people have stopped coming. Since the border states have become unfriendly to immigration, they are going further, and the problem is surfacing elsewhere," says Boettcher, vice president for continuum of care for Scott and White Healthcare, with headquarters in Temple, TX, and consultant for the Center for Case Management, a patient care management consulting firm based in Wellesley, MA.

Anne Meara, RN, MBA, assistant vice president for network care management for Montefiore Medical Center in the Bronx, NY, reports that her hospital regularly provides care for undocumented immigrants and often keeps them a long time if they have a catastrophic medical event and need post-discharge services. "It takes creative thinking and the understanding of the dynamics of each individual case to find care for these patients," Meara says.

One avenue to finding post-acute funding for undocumented patients is to file a Permanently Residing Under Color of Law (PRUCOL) application with U.S. Citizenship and Immigration Services, Meara says. PRUCOL status indicates that immigration services has no intention of deporting the person and makes it possible to apply for Medicaid benefits.

EXECUTIVE SUMMARY

Hospitals across the country are providing care for undocumented immigrants, often at great expense when they need post-acute care.

- Many have long lengths of stay when they can't be safely discharged and don't have funding for another level of care.
- Some may qualify for Medicaid benefits if their Permanently Residing Under Color of Law (PRUCOL) application is accepted.
- In some cases, it may be financially advantageous to the hospital to transport the patient back to their native countries for care.

Montefiore has secured grant funding that provides patients with legal representation including PRUCOL, tenant-landlord disputes, and visa adjustment issues. "The wheels turn very slowly. Patients may be here for months or years until we get all the pieces in place," Meara says.

The PRUCOL application process takes three to six months or longer, but once the hospital gets a notice saying the patient is not facing deportation, the case manager coordinates with the hospital finance department to help the patient file a Medicaid application. Once the application is filed, the hospital can discharge the patients to a skilled nursing facility, and absorb the cost of the stay in the skilled nursing facility, until Medicaid reimbursement kicks in.

For instance, the hospital was successful in getting Medicaid status approved for an undocumented young man who was shot in the course of a robbery, suffered paralysis, and needed specialty wound care in a skilled nursing facility. After discharge, the young man developed more problems, and is back in the skilled nursing facility with a wound management device and IV antibiotics. "The Medicaid rate for skilled nursing care doesn't cover half of what his care costs," he says.

Boettcher adds that hospitals have to decide if they are going to become a lifetime payer for brain injured, ventilator dependent citizens of other countries, or transport them back to their country of origin where they are eligible for national health benefits, he says.

Hospitals in border states and other areas with a high number of undocumented immigrants need to develop a relationship with foreign consultants and Embassies, he says. When Boettcher was director of case management for a Phoenix, AZ, health system, the health system had a relationship with the Mexican consultant and specialized contract with air ambulance companies. The health system sent physicians to visit hospitals in Mexico and found that some were quite good, including one that was certified by the Joint Commission, he says.

In most hospitals, ventilator dependent patients are going to have to be in the intensive care unit, which can run into tens of thousands of dollars. Hospitals can save a fortune if they transfer these patients to a hospital in their native country that can care for them, he says.

SOURCE

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Think like a payer when patients are uninsured

Decide in advance what and who to cover

In order to provide consistent post-acute care for uninsured or under insured patients, hospitals need to think like payers and develop a payment assistance policy so that at admission or registration, a financial counselor can do a quick assessment and determine who qualifies and who doesn't, according to Matt Boettcher, LSW, MSW, vice president for continuum of care for Scott and White Healthcare, with headquarters in Temple, TX, and consultant for the Center for Case Management, a patient care management consulting firm based in Wellesley, MA.

"When hospitals are in the position of providing care for the uninsured, they are not just being the provider of care, they are becoming the payer of care and they need to act like a payer," he says. When case managers call payers to get an admission or procedure approved, they get a decision on the spot. Hospitals need to have a plan to make the same kind of real-time decisions on care for uninsured or under insured patients, he says.

With 20% of Americans without health insurance, planning for care for uninsured patients is more than a once-in-a-while occurrence. "Providing care for unfunded patients is the norm these days. Hospitals need to develop a plan and avoid having to reinvent the wheel every time they get an uninsured patient," he says.

It's not a good idea to just have a committee that meets once a week. Instead, Boettcher recommends setting up criteria so the staff can make a decision in real time. "It doesn't pay for a patient to stay in the hospital until the committee meets on Friday, if the patient is medically ready to leave on Tuesday," he says.

Boettcher suggests that the policy be developed by a team that includes representatives from case manage-

EXECUTIVE SUMMARY

Hospitals need to develop a detailed policy of when and how they'll provide post-acute financial assistance for uninsured or under-insured patients.

- The policy should allow staff to get real time decisions about what will be covered.
- Staff should apply the policy consistently to all patients in all situations.
- A policy frees up case managers to coordinate care for all their patients rather than spending hours at a time trying to line up post-acute care for unfunded patients.

ment, admissions, registration, finance, and the physician staff. The policy should state for which patients you will provide charity care, and when you will not, and should be based on financial criteria.

For instance, the hospital may decide to pay for post-discharge services if a patient's income is at 250% of the federal poverty level, and pay half if the patient's income is 350% of the poverty level. Whatever policy your hospital develops, it must be applied to every patient in the same way, he says.

"Hospitals must follow the policy consistently and not have the appearance of favoritism," he says. For instance, hospitals shouldn't put themselves in the position of paying for post-acute care for a patient of a doctor who admits a lot of patients, and refusing to do so for other patients in the same financial situation.

At Scott and White, when a patient doesn't need a walker, a prescription, or transportation to the doctor, the case manager can determine if the patient qualifies, and set it up on the same day. "This is an effective way to make a decision and it's the way a health plan functions," he says.

A well-developed plan to provide post-discharge assistance for the uninsured helps everyone. The case managers can spend their time with all of their patients. The hospital doesn't make a decision every time there's an uninsured patient who needs post-acute care, and the patients can get the services they need.

"I want my case management and social work staff to be able to provide good care to all patients. Calling pharmacies for prescription assistance, or trying to get a skilled nursing facility to take a charity case can take an entire day and the case manager's other patients get nothing," he says. ■

Proactive approach identifies benefits

Patients are targeted early in their stay

Faced with an increasing number of patients who have no insurance and can't afford to pay for their own care, the University of Iowa Hospitals and Clinics in Iowa City, has developed a multi-pronged approach to identify indigent patients early in their stay and help them get access to community providers who can provide ongoing care.

"Like every other hospital, we're seeing an increase in indigent patients. Many of these patients don't see a primary care physician and when they hit the hospital, they have major problems, such as cellulitis of the feet in patients with uncontrolled diabetes. Most

CASE MANAGEMENT

Case manager to case manager

INSIDER

The case management process in effective and efficient action

By Toni Cesta, PhD, RN, FAAN

Senior Vice President

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Brooklyn, NY

Case management follows a process, not unlike the clinical nursing process or social work process. By following a process, case managers can function more effectively and efficiently. They will also have a higher likelihood of achieving meaningful outcomes for themselves, their patients and their organization. A process is defined as a systematic series of actions, changes or functions directed to some end. Like some processes, the case management process is not a linear one. Rather, it is a series of non-linear steps that may sometimes go out of order or may have to be repeated. This is to be expected in the field of case management. Algorithms are processes that cannot be deviated from under any circumstances. They are considered "hard wired." The case management process, however, is not hard wired, and may take a variety of twists and turns as the patient moves toward transition or discharge from the hospital.

As we have discussed in prior issues of *Case Management Insider*, case managers and social workers perform a series of functions within the roles that they are responsible for. These functions are performed using the case management process to guide the case manager toward the expected goals that they are aiming to achieve.

Selection and screening

The first step in the case management process is the selection of patients in need of case management interventions. In the hospital setting, the

selection of patients will be dependent on the type of model in place. In order to know the expectations of the case manager in this first step, the case manager will need to know the structure that they are working within, and how patients are assigned to them.

In some hospitals, every patient is followed by a case manager. If the hospital's model is designed in this way, then the case manager's caseload or selection of patients is dependant on their bed, unit assignment or perhaps geographical area that they are responsible for. In other models, the case manager may be responsible for managing patients with specific diagnoses or specific payer sources. Some may follow a product line such as trauma or cardiac services. Others may be responsible for patients under a particular physician or hospitalist. In each of these approaches, it is fairly clear how the patients are assigned to a specific case manager. If the hospital's model is that every patient is followed by a case manager, then there is no need for the case manager to screen the patient prior to assessing them. This step is eliminated. The same logic would apply to models linked to a specific diagnosis or physician. By virtue of the linkage, the case manager automatically has that patient in their caseload.

If your model is not an "all comers" model, then your hospital must use high-risk criteria to determine which patients would be followed by the case manager. If your hospital uses this approach, a screening will need to take place in order to determine whether or not the patient meets these pre-determined high-risk inclusion criteria. With this type of approach, the case manager must collect relevant information to determine whether or not the patient meets the pre-selected inclusion criteria.

In some instances, a member of the healthcare

team may make a referral to the case manager directly. From either point, the case manager must then collect relevant data from a number of data sources. This data will help the case manager to determine whether or not they will pick up the patient as an active member of their caseload.

Data sources for case management screening

Multiple data sources are needed to be accessed as the case manager works through the screening process. Data sources include:

- the patient's current medical record;
- the patient's prior medical record;
- the patient's out-patient record if available;
- other members of the healthcare team;
- the patient and family.

This information is then compared to the predetermined inclusion criteria. If there is a match, the patient is selected to be followed by a case manager while they are in the hospital.

The screening process is the first step in identifying the case manager's caseload of patients. The number of patients to be followed is also dependent on how the department's infrastructure is designed.

High risk criteria

For models where not all patients are followed by a case manager, this screening criteria list can be used to determine whether the patient needs case management services while they are in the hospital:

- specific diagnoses;
- specific physician;
- specific payer sources;
- multiple physicians involved in case;
- non-adherence issues;
- complex discharge educational needs;
- frequent emergency department admissions;
- high tech needs such as ventilators, IVs;
- discharge placement needs such as home care, rehab;
- multiple system requirements for home care;
- adult day care needs;
- frail elderly;
- guardianship or conservatorship;
- medically indigent (under or uninsured);
- potential / suspected abuse;
- hospice;
- frequent readmissions;
- additional specific issues.

Each hospital has to determine its own "high-risk" criteria based on its own unique patient population and community issues. ■

Patient assessment and diagnosis

By Toni Cesta, PhD, RN, FAAN

Senior Vice President

Lutheran Medical Center

Brooklyn, NY

Once the patients requiring case management have been identified, the case manager must then perform an assessment. The assessment is the key to determining what interventions the case manager and social worker may need to apply in order to achieve the expected outcomes for the patient. The case management assessment differs from the traditional clinical assessment completed by the staff nurse or the physician. It encompasses additional elements that are needed to determine the case management plan for that specific patient. The three broad categories of the assessment include clinical, psychosocial and financial.

The first question that the case manager must always ask is, "why is this patient in the hospital?" The answer to this single question will provide the case manager with a significant amount of important information.

For case management, why the patient is in the hospital may have nothing to do with the admitting diagnosis. A family member may have left the patient in the emergency department. The patient may be unable to care for himself or herself at home. The patient may have neglected to take one or more doses of medication at home, thereby resulting in an exacerbation of their illness.

The patient's clinical picture must be taken within the context of the psychosocial and financial information. For example, the patient may not have taken their medication because they could not afford the co-pay, or the patient may be confused or unable to care for themselves in their current living situation.

Where does the data come from?

The case manager will harvest data and information from a number of sources. This process should be structured so that by the time that the case manager interviews the patient and family, they will have already gathered the information that will help them to ask the right and most pertinent questions of them. If possible, the case manager should review the patient's prior clinical record. As more hospitals move

toward electronic review the current medical record, sometimes not all relevant information is available early on. This should not delay the case management process however.

In addition to obtaining information from the current and prior medical records, the case manager should speak with the physician. This will help the case manager understand what the physician's reason for admission is, and what the anticipated plan of care is, as well. The case manager should also discuss any findings that the staff nurse may have that will inform the discharge plan as well as the in-patient stay.

If the patient was admitted via the emergency department, the case manager will want to speak with the emergency department case manager and/or review the emergency department case manager's notes. ■

Using the data for the discharge plan

All the information gathered by the case manager will help to determine the initial discharge plan. Eighty percent of the time this initial discharge plan will become the final discharge plan. By doing an early assessment, the case manager can expedite the process so that there are no delays as the patient moves toward discharge from the hospital. The patient's clinical issues and needs must be crossed match with their psychosocial and financial issues. Only through the integration of this information can the case manager coordinate the stay and the discharge plan adequately.

Discharge destination correlations

The majority of the time, the anticipated discharge plan can be based on where the patient was admitted from, whether or not they have a chronic condition or if they are having surgery and what type of surgery.

- admitted from nursing home — discharged to nursing home;
- admitted with prior home care use — discharged with home care;
- admitted with chronic condition — discharged with home care;
- admitted for surgery — discharged with home care.

These correlations will be correct 80% of the time.

A standard case management assessment tool can be used to help collect and organize all the relevant information that the case manager needs to make a comprehensive plan for the in-patient stay as well as the best discharge plan possible.

Next month, we will continue with the additional steps in the case management process. ■

Performing the necessary assessments

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

Assessments that must be performed include clinical, psychosocial and of course, financial. The clinical assessment includes the gathering of relevant clinical information that will help the case manager in the performance of the roles that we have discussed in prior issues of *Case Management Insider*. This data should include the daily clinical needs of the patient. These needs will be coordinated and facilitated by the case manager, so the case manager must know exactly what the plan is for each day that the patient is in the hospital as well as the plan following the acute care episode. This information also assists the case manager in communicating with the third party payer in the performance of their role in utilization review. By having the most current clinical information, the case manager is in a great position to provide the most complete information to the third party payer, thereby increasing the chance of approval for reimbursement. (*For an example of a case management admission assessment, see box, p. 58.*)

Psychosocial assessment

The psychosocial assessment has two principal goals. The first is to help to identify any immediate needs that the patient or family may have while the patient is in the hospital. The second is to identify any barriers to a safe and appropriate discharge from the hospital.

The case manager can complete the initial psychosocial assessment. This assessment includes the family as well as the patient. Once the case manager has identified any potential psychosocial problems or issues, a referral can be made to the social worker for follow-up.

For example, if the family is having difficulty coping with the patient's illness and hospitalization, a referral to the social worker would be appropriate. If the family had been caring for the patient at home but are no longer able to do so, this too would warrant a referral to the social worker.

The case manager must also assess the patient for financial risks or concerns. These may include insurance coverage issues, coverage for continuing care

services in the community, Medicare lifetime reserve days, the need for Medicaid, and so on. The case manager should review this information in the context of the reason for hospitalization as well as the

patient's benefits following discharge. The best discharge plan may not be able to be implemented if the patient does not have coverage for that service in the community. ■

Case Management Admission Assessment

Date of Admission _____

Patient Name _____

Room _____

Medical Record Number _____

Registration _____

Diagnosis _____

History _____

Language: English Other _____

Next of kin _____ Telephone Number _____

Advance directives _____

Patient able to make needs known Yes No

Referral Source

- Clinic _____ ED
 Private MD _____
 Long-term care facility _____
 Other _____

Can patient return: Yes No Unknown at this time

Insurance information

Primary _____ Contact _____

Secondary _____ Contact _____

Discharge service covered _____

Preferred provider _____

Medicaid eligible: Yes No Unknown

Referred date _____

Comments _____

Prior to admission

Living arrangements _____

Apartment/house: Elevator Stairs _____

Comments _____

Nursing home

Bed hold Yes No Unknown

Adult home Shelter Homeless Other

Comments _____

Activities of daily living Dependent Independent

Assistive device Yes _____ type of device

Dependent Independent

Supports

Informal Yes No Formal Yes No

Service(s) _____ Service(s) _____

Provider(s) Family Friend

Agency/vendor _____

Name _____

Referred Yes No Date _____

Telephone _____ Contact _____

Equipment in Home

Yes No Vendor _____

Oxygen Commode Assistive device Other

Does patient meet social work high-risk screens? Yes No

Referred to: _____ Date _____

Does patient meet home care screens? Yes No

Discharge plan: Same as prior to admission

Unclear at present New plan

Other _____

Continuing care resources _____

Equipment Needed

Same as prior to admission Unclear at present

Other _____

Vendor _____ Date _____

Mode of transportation for discharge: None Auto

Public Taxi/car service Ambulette

Ambulance _____

Who will accompany patient? No one Family/friend

Home attendant/home health aide

Name _____

Comments _____

Medical follow-up with: Clinic _____

Other _____ Private MD _____

Does this patient have adequate financial supports for a safe discharge?

Yes No _____

Acute hospital treatment plan: Discussed with MD

Chart Review

Comments _____

Case Manager Name _____

Date _____

Signature _____

of these patients have complex medical needs and will need additional care after discharge," she says **Rosie Wilhelm**, ACSW, LSW, director of social services for the 729-bed tertiary care hospital.

The hospital has dedicated social work staff that screen the patients for eligibility for categorical and entitle programs and pharmacy assistance programs. The hospital's goal is to make sure every self-patient is seen and screened for eligibility for programs that would help pay for their medical care and ongoing needs, Wilhelm says.

To help patients who may qualify for financial assistance programs, the hospital has a staff of 12 healthcare benefit assistance program social workers whose role is to educate patients and families about financial options and to help them apply for Medicaid, Social Security Disability, the Crime Victims Compensation Program and IowaCare. IowaCare is a Medicaid Demonstration Waiver Program that covers adults between the ages of 19 and 64, without insurances and with incomes of up to 200% of the poverty level. Patients who receive IowaCare benefits receive primary care at regional medical homes. When they are hospitalized, their care is provided at University of Iowa Hospitals and Clinics in Iowa City or Broadlawns Medical Center in Des Moines.

The healthcare benefit assistance program social workers receive training from the Iowa Department of Human Services to complete the applications for Medicaid and IowaCare. They get referrals from the hospital's business office and social workers. They visit the patient and family at the bedside, screen them for eligibility, and help them fill up the applications.

Many of the patients do not know that they may be eligible for the programs and feel overwhelmed by the process. "Enrolling can be confusing, so being able to provide this one-on-one assistance at the hospital bed-

EXECUTIVE SUMMARY

The University of Iowa Hospitals and Clinics in Iowa City, has developed strategies to identify uninsured patients early in the stay, and help them access ongoing care in the community.

- Twelve healthcare benefit assistance program social workers educate patients and families about financial options and help them apply for government-sponsored programs.
- Through a Revolving Fund agreement, the hospital pays the Medicaid rate to post-acute facilities while patients' Social Security Disability is pending and is paid back when the disability coverage is approved.
- Dedicated social workers help patients who need brand name medications and can't afford them sign up for national pharmaceutical assistance programs.

side is invaluable," Wilhelm says.

With the healthcare benefit assistance program, social workers follow patients after discharge until their application is approved or denied. IowaCare benefits are usually approved within three to 30 days. It could take as long as two years for Social Security Disability benefits to be approved.

"This is a wonderful program for patients and the hospital. If patients are approved for retroactive Medicaid, the patient no longer has to worry about the charges, and the hospital has a revenue source," she says.

When unfunded patients need post-acute care, the hospital may pay the Medicaid rate for patients to receive care in a nursing home or rehabilitation facility while their Social Security disability is pending, under a 28E agreement with the Iowa Department of Human Services called the Revolving Fund. When the disability payments are approved and the patient qualified for Iowa Medicaid, the receiving facility bills Medicaid and pays back the hospital.

"We have been using Revolving Funds since the 1980s and it has been extremely successful. We compare the cost of keeping patients in acute care hospital and the cost of transferring them to a more appropriate level of care. There are advantages of moving the patient to the care setting they need, and to increasing the hospital's capacity to accept more acute patients," she says.

To help patients who cannot afford name brand medications, University of Iowa Hospitals and Clinics has five social workers who identify and enroll patients eligible for national pharmaceutical assistance for brand name medications. "This program has been very successful in helping people get the medication they need to avoid a readmission. If patients can't afford their medication to keep their medical status stable, they will be back in the emergency department or the hospital," Wilhelm says.

SOURCE

- **Rosie Wilhelm**, ACSW, LSW, Director of Social Services, University of Iowa Hospitals and Clinics, Iowa City. Email: rosemary-wilhelm@uiowa.edu. ■

Community wide effort assists uninsured, homeless

Providers, agencies team up to provide care

In its efforts to ensure that the uninsured and homeless receive the healthcare services they need, Carondelet Health Network in Tucson, AZ,

EXECUTIVE SUMMARY

- Carondelet Health Network in Tucson, AZ, takes a multi-pronged approach to ensuring that uninsured and homeless patients receive the healthcare services they need.
- A community-wide collaboration, instigated by the health network, provides services for community residents, including respite beds in homeless shelters, and a mobile medical van that travels to community locations to provide care.
 - The health system has agreements with post-acute facilities to provide care for uninsured patients at discounted rates.
 - Emergency department navigators help patients without a primary care provider find a medical home.

has developed a list of community resources and partnered with community agencies to provide care for patients underserved patients. (*For more details, see related story, right.*)

Using a \$2 million donation, the health system has brought together a number of community agencies to create the South Arizona Health Village for the Homeless, a virtual village that provides services for homeless residents. “We are trying to bring together everybody who works with the homeless so we can provide the services our community needs without duplication,” says **Donna Zazworsky, RN, MS, CCM, FAAN**, vice president of community health and continuum care for Carondelet Health Network in Tucson, AZ.

The organization purchased a 38-foot recreational vehicle, equipped it to provide mobile medical services and named it the Van of Hope. The van is licensed through a federally qualified health center and staffed by a nurse practitioner, a medical assistant and a community health outreach worker, and provides health assessments, medical treatment, medications, case management, specialty care, and tele-behavioral healthcare in the community. It travels to 19 different locations, including churches and shelters, on a schedule that is publicized in the communities and distributed to community agencies, case managers and emergency department staff in local hospitals.

The organization created respite care beds in two shelters for the homeless, and is able to fund home health visits when patients need them. When homeless patients need post-acute services, the hospital case managers can place them in the shelter beds and arrange for a home health agency to provide services. “If the nurse practitioner on the van finds homeless patients who are on the edge and could end up being hospitalized, they can put

them in respite care beds in a shelter, to stabilize them so their conditions don’t get worse,” she says.

The health system has set up preferred provider agreements with local skilled nursing facilities that agree to follow Carondelet’s quality guidelines. In return for referrals from patients who can pay, the nursing facilities agree to take the uninsured patients at a discounted rate. The health system also contracts with other nursing facilities to take patients on an individual basis, paying different rates for basic care, moderate care, and high care. The hospital case managers work with assisted living centers that will take uninsured patients at a discounted rate for a short-term stay. “We are looking at developing preferred provider arrangements rather than negotiating on an individual basis,” Zazworsky says. ■

ED Navigator helps patients find a PCP

Pilot steers patients to appropriate level of care

When patients without a primary care provider come into the emergency department at St. Mary’s Hospital in Tucson, AZ, Renee Perez, the hospital’s community health outreach coordinator/emergency department navigator helps them get follow-up care.

The initiative is a pilot program begun by Carondelet Health Network in late 2011 that primarily targets frequent flyers who use the emergency department for primary care, says **Donna Zazworsky, RN, MS, CCM, FAAN**, vice president of community health and continuum care for Carondelet Health Network in Tucson, AZ. Emergency department physicians and case managers refer patient to the navigator who works with them to identify a medical home and make an appointment. “Most of these patients do not realize that there are other resources out there where they can receive care at a reduced rate,” Zazworsky says.

Perez adds that the navigation program is an adjunct to the health system’s long-standing initiative to help the uninsured identify and sign up for healthcare assistance programs. Many of the patients Perez assists in the navigation program use the emergency department for primary care. “We want to help them find a medical home so they don’t come to the emergency department for a non-emergency situation,” she says.

Perez receives referrals from the physicians and case managers in the emergency department. If patients are uninsured, she screens them for eligibility for assistance programs and sets an appointment for them at a clinic that offers primary care at no cost or on a sliding scale. The key to the success of the program is not just making the appointment, but following up to make sure the patient is seen by the primary care provider in a timely manner.

If patients are insured but don't have a primary care provider, she helps them identify a provider and make an appointment. "The patients get the care they need in the emergency department, then I coordinate the follow up appointment with a primary care provider. Some patients need follow up the next day; others can wait longer. I call the clinics and make sure they get an appointment in a timely manner," she says.

Zazworsky adds that if patients have a primary care physician but all the appointment slots are booked, the emergency department navigators try to get the primary care office to work the patient in. If that doesn't work, they refer the patients to walk-in clinics operated by the health network's medical group to take care of their immediate needs while they wait for an appointment with their primary care provider. "It's all about access to care," she says.

Perez works closely with the clinics and calls to make sure the patient showed up for follow-up care. If not, she calls the patient and offers to reschedule the visit.

"It's too early to have data, but when we are documenting every visit and we're seeing good success with patients following up with the clinic," she says.

SOURCE

- **Renee Perez**, Community Health Outreach Coordinator/Emergency Department Navigator, St. Mary's Hospital, Tucson, AZ. Email:rperez@carondelet.org. ■

Dedicated CM coordinates discharges for patients

Position frees up CMs, SWs time

At Montefiore Medical Center in the Bronx, NY, a complex care case manager coordinates appropriate post-discharge options for uninsured and under-insured patients who are likely to need complex care after discharge.

"We're seeing more patients with complex needs,

especially those who are uninsured or underinsured, and who require too much care to be discharged to home. These patients do not fit into traditional niches, making it difficult and time consuming to find appropriate placement in the community. Having someone who is dedicated to finding and coordinating post-discharge care for the difficult-to-place patients frees up the case managers and social workers to concentrate on moving other, less complex patients through the system," says **M. Alexander Alvarez**, RN, director of the care management resource unit at the 1,491-bed medical center, located in one of the poorest counties in the country.

Anne Meara, RN, MBA, assistant vice president for network care management for Montefiore Medical Center adds that the hospital is seeing an increasing number of patients with complex needs, especially those who are uninsured and underinsured and who require too much care to safely be discharged to home. "Each case involves a lot of complex issues whether it's people with developmental disabilities who can no longer be taken care of by their family, patients with immigration status issues, housing issues, complex clinical needs, or any combination. It's the role of the complex care case manager to be an expert on all the resources in the community and help the patient get access," Meara says.

The social workers and case managers refer cases that need a focused level of intervention to the complex care case manager, who began work in December, 2011. Before that, Alvarez and nurse and social work managers worked on these cases along with their other duties. Recently, the complex care case manager was coordinating post-acute care for 43 patients.

When the complex care case manager receives a referral, she gets the patient, the family and/or caregivers and the treatment team together to identify an appropriate venue of care, what assistance programs the patient might qualify for, and what documents the

EXECUTIVE SUMMARY

Montefiore Medical Center in Bronx, NY, has a complex case manager who coordinates post-discharge options for uninsured patients with complex needs.

- The initiative frees up unit case managers and social workers to manage the care of less complex patients.
- The hospital has an arrangement with a community-based organization to provide a safe living environment for patients who are homeless and need post-acute services.
- A complex care advisory team reviews patients with post-discharge issues and makes a recommendation to the hospital's administration.

patient needs to establish eligibility.

To meet the needs of unstably housed and homeless patients who require post-acute care in the community, the hospital has entered into a contract with Comunilife, a non-profit, community-based organization that provides a broad array of services including housing. The complex care case manager collaborates with Comunilife to identify post-discharge options for homeless patients with multiple problems who are likely to have complex issues after discharge. For instance, the patients may need IV therapy or dressing changes. The patient is discharged to a respite care bed in a Comunilife facility in the community.

"The organization provides a safe environment where homeless patients can go and receive home care and other services," Meara says. The partnership between Montefiore and Comunilife evolved from the need to provide a safe post-acute environment for medically stable patients whose housing situation was a barrier to receiving needed, ongoing care in the community, she says. Comunilife has case management services that work with patients on long-term plans, such as finding permanent housing.

For instance, Montefiore worked with Comunilife to find services for one patient who had medical issues that required post-acute care. Returning to her pre-hospitalization housing situation with a family member was not an option at the time of discharge. "Without the partnership with Comunilife, this patient would have been in the hospital for an extended period of time while alternate living arrangements were explored," Meara says. The patient was discharged to Comunilife where she received home care services while a case manager worked with her to arrange permanent housing in an assisted living center, where she received supportive services. The patient has not been readmitted to the hospital.

Alvarez adds that the hospital is the safety net for people with psycho-social needs as well as the complex medically ill patients. For instance, a family dropped off an autistic teenager in the emergency department when his behavior could no longer be managed at home. "He wasn't physically ill but he didn't have a place to go. A lot of people think that the hospital is a safe place and that it's OK for people to stay here for a long time," he says. The young man stayed in the hospital several months while the hospital staff worked with the family and community and governmental organizations to determine the most appropriate long-term placement. While the young man was hospitalized, a multidisciplinary team collaborated to formulate a plan to deal with behavioral issues arising on the unit. One outcome was that

arrangements were made his for him to go to the rehabilitation department every day and exercise to work off energy. His social worker accompanied the boy's mother on a tour of the residential facility that was identified as an appropriate place for the boy. "Often we go way beyond the medical boundaries when people have a lot of complex issues," Alvarez adds.

The hospital has assembled a complex case advisory team to review post-discharge issues and come up with a plan to present to the hospital's senior leadership.

The complex case advisory team includes a physician from the office of the medical director, and representatives from nursing, bioethics, legal, risk management, social work, and customer service. The committee meets every two weeks and invites members of the treatment team to bring in cases for review.

SOURCE

- **Anne Meara, RN, MBA, Assistant Vice President for Network Care Management, Montefiore Medical Center, Bronx, NY.** Email: AMEARA@montefiore.org. ■

Community joins forces to care for uninsured

Hospitals, agencies collaborate on post-acute care

In Lee County Florida, providing healthcare for the uninsured and under insured is a community-wide effort, according to **Chris Nesheim, RN, MS, CMAC**, system director, case management, Lee Memorial Health system with headquarters in Ft. Myers, FL.

Located in Southwest Florida, Lee County has been one of the country's areas hardest hit by the economic downturn. Many residents in the construction, real estate, and hospitality industry have lost their jobs in the past few years, and the area also is home to a tre-

EXECUTIVE SUMMARY

Faced with a high rate of unemployment and an increase in uninsured patients, Lee Memorial Health system in Ft. Myers, FL sponsored a community-wide effort to provide health care options for unfunded patients.

- Triage Center provides post-acute medical care for the homeless.
- Salvation Army operates 10-bed respite unit that provides skilled nursing services for homeless.
- Hospital operates free clinics for the uninsured.

mendous number of Medicare recipients, both retirees and “snow birds” who spend the winter months in the area.

“We have a 10.2% rate of unemployment, which was 13% at its highest, and an increase in residents with no insurance or minimal insurance benefits. We coordinate with a lot of community organizations to find places where patients can get the care they need to avoid inappropriate hospital admissions, and be discharged to another level of care when they no longer meet inpatient criteria,” she says.

Lee Memorial Health System, one of the largest not-for-profit public hospital systems in Florida, includes four acute-care hospitals and two specialty hospitals with a total of 1,600 acute care beds. The health system experiences nearly 80,000 admissions a year with 47% of them coming through the emergency department.

Case managers and social workers in the emergency department coordinate community services and facilitate placement for patients who do not meet criteria but cannot be safely discharged. They work with “special needs” patients who have frequent emergency department visits to develop a plan for care in an appropriate setting.

In 2007 Lee Memorial Health System sponsored a community-wide collaborative, Community Health Visioning 2017, to create a decade-long vision and initiatives for healthcare that would improve the health status for residents of Lee County with each partner in the collaborative contributing their own unique assets.

For instance, the hospital system collaborated with Lee Mental Health, Southwest Florida Addiction Services, the Salvation Army, and the Lee County Sheriff's office to develop a Behavioral Triage Center and a Low Demand Shelter. The triage center, operated by the Salvation Army with funding from the hospital provides post-acute medical care for the homeless and provides law enforcement and hospital emergency departments with alternatives to jailing, or hospitalizing people with symptoms of mental illness.

When patients don't meet admissions criteria but can't go home safely, the hospitals may send them to The Salvation Army's 10-bed medical respite unit for homeless patients who need skilled nursing services such as IV infusion, dressing changes, and medical care.

Managed by the Salvation Army, “We Care,” the latest collaboration between Lee County Health Department, Family Health Centers, the Lee County Medical Association, and the Southwest Florida Community Foundation, provides specialty medical care at no charge to Lee County residents with a medically necessary/life altering condition that can-

not be managed by a primary care physician. The patients must be unemployed or the working poor, and must meet financial eligibility standards. Patients are referred to the program by primary care physicians, participating medical specialists, or emergency department physicians. When an eligible patient presents to the emergency department, the case manager or social worker calls the “We Care” coordinator who sets up an appointment with a participating specialist.

In addition, the hospital system has partnered with the community and has opened two indigent clinics (Lee Physician Group Clinics) for the uninsured in buildings that also house United Way agencies that can provide help with social needs such as housing and utility assistance, signing up for food stamps, medical assistance, and other services. The hospital refers patients who use the emergency department for primary care and hospitalized patients with no funding to the clinics for follow-up care. “The collaboration between the health system and the community agencies makes it possible for people to get many sources of needed assistance in one location,” Nesheim says.

The health system has contracts with local pharmacies to subsidize the cost of medication until patients can get long-term solutions through Family Health Centers, Lee Physician Group Clinic or other programs, and is working to open its own outpatient pharmacy and to develop a medication assistance program for patients who can't afford their medications, Nesheim says. ■

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 healthcare 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

■ What case management model will work best for you?

■ Tips for dealing with difficult patients.

■ Why ED case management is more important than ever.

■ How your peers are reducing readmissions.

CNE QUESTIONS

1. When the Foundation for Health Coverage Education conducted a survey of uninsured patients who presented to the emergency department in a large hospital system in California, what percentage of patient were eligible for health coverage programs but didn't know it?
 - A. 75%
 - B. 50.22%
 - C. 80.54%
 - D. 15.3%
2. True or False: According to Matt Boettcher, LSW, MSW, vice president for continuum of care for Scott and White Healthcare, Temple, TX, hospitals should develop a payment policy so that at admission or registration, a financial counselor can do a quick assessment and determine who qualifies and who doesn't.
 - A. True
 - B. False
3. According to Rosie Wilhelm, ACSW, LSW, director of social services for University of Iowa Hospitals and Clinics, how long does it take for patients to be approved for Social Security Disability?
 - A. Up to a year.
 - B. Up to two years.
 - C. Three to four months.
 - D. Several days.
4. At Montefiore Medical Center in Bronx, NY, what is the role of the complex care case manager?
 - A. To find and coordinate care for difficult to place patients.
 - B. To manage the day-to-day care of patients with complex medical needs.
 - C. To help uninsured patients sign up for financial assistance.
 - D. All of the above.

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.cmcity.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. ■

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