HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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CM experts: Hospitals need ED case managers now more than ever

Expertise needed for medical necessity, intervening with frequent users

These days, if hospitals don't have case managers in the emergency department, especially during peak hours, they run the risk of losing reimbursement as well as having their facility inundated with repeat users who don't have the resources to manage their healthcare in the community.

"Case management in the emergency department came late to the table because for a lot of years, having a social worker was more immediately helpful for crises and psychiatric patients. But now, most hospitals have realized the advantages of adding an RN case manager in the emergency department," says **Karen Zander**, RN, MS, CMAC, FAAN, principal and co-owner of The Center for Case Management in Wellesley, MA.

The Centers for Medicare & Medicaid Services' Recovery Audit Program put emergency department case management on the map, Zander points out. "It's now clear to most hospital administrators that emergency departments require clinicians who have the kind of expertise needed to work closely with

EXECUTIVE SUMMARY

It's no longer a luxury for hospitals to have case managers in their emergency departments, according to some case management experts — it's a necessity to make sure patients are admitted in the proper status and to ensure that those being discharged from the emergency department have what they need to manage their conditions.

- Hospitals need to ensure that patients meet medical necessity criteria to avoid losing reimbursement.
- Case managers can help provide a smooth transition from the emergency department back to the community and connect patients with post-discharge services.
- Case managers can work with patients who frequently utilize the emergency department and educate them about more appropriate venues of care.

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the treatment team, and to evaluate whether patients meet medical necessity criteria and are placed in the proper status, but emergency department case managers can do a lot more than just advise physicians about the correct patient status," she says. *(For a look at how emergency department case managers can help connect patients to the community, see related article on page 149.)*

There's a tremendous need for case managers and discharge planners, not just for patients who are admitted to the hospital but also for patients who are treated and discharged from the emergency department, says **Jay Kaplan**, MD, FACEP, director of service and operational excellence for CEP America, based in Emeryville, CA, and a member of the board of directors of the American College of Emergency Physicians. "Case managers can play a key role in transition of care from the emergency department to the community because no other clinical service interfaces with more members the community," he says.

Social workers also are critical in the emergency department to determine if patients' psychosocial needs are driving their emergency department visits, adds **Beverly Cunningham**, RN, MS, vice president, clinical performance improvement at Medical City Dallas Hospital.

The number of social workers and case managers staffing an emergency department depends on the types of patients the hospital treats, she says. For instance, hospitals where a large percentage of emergency department patients are Medicaid beneficiaries, chronically ill, or are uninsured may need more social workers than case managers, while it may be a different story at hospitals that treat only a small percentage of patients with Medicaid, she adds.

Case managers in the emergency department can provide essential services to benefit the hospital as well as patients. They can assist physicians in deciding whether patients should be admitted or receive observation services. They can do discharge planning after patients are treated and discharged if they need post-discharge services such as home health visits, durable medical equipment, or follow-up care. They can help steer patients who have non-emergent needs to a more appropriate level of care after they are triaged. They can intervene with frequent utilizers and help them access community resources that can help them stay out of the hospital.

At some hospitals, off-site RN case managers are remotely reviewing the electronic medical records and assisting physicians with determining whether patients meet admission criteria and determining level of care, Cunningham adds.

At Medical City Dallas Hospital, RN case managers who work at home with remote access to the hospital electronic medical record work with the emergency department physicians to determine the patient status and level of care on admission. The hospital also has emergency department case managers who cover the clinical decision unit and work with physicians when more information is

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Editorial Questions
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needed to determine if the patient meets admission criteria.

The hospital started using the remote case managers to cover weekends two years ago but expanded the program to cover 24 hours a day, seven days a week.

"For the initial review, the off-site case manager reviews the documentation to determine if the medical record supports the patient status. The off-site reviewers do not need to see the patients for this step in the utilization process," says **Pat Wilson**, RN, BSN, MBA, director of case management.

When patients are registered in the emergency department, it shows up on the system board that is part of the electronic medical record and the remote case manager is alerted that the patient is in the house.

"They can see everything they need to review the record and work with the physician over the telephone while the decision is being made by the physician to admit patients or begin observation services," Wilson says.

The remote case managers send a daily report by e-mail to the hospital-based case managers, letting them know what happened with the patients and what still needs to be done as part of the hand-off communication. In addition, the emergency department case manager sends a work list to the remote case manager.

The hospital contracts with an external physician advisor to review cases for admission criteria whenever appropriate.

It's to the hospital's advantage to have a nurse case manager in the emergency department to set up post-acute care for patients who need it after being treated, and to help patients with non-emergent conditions obtain care at a primary care facility, adds **B.K. Kizziar**, RN-BC, CCM, CLP, owner of BK & Associates, a Southlake, TX, consulting firm specializing in hospital case management.

Often patients return to the emergency department for the same problem within a short period of time because they didn't get the follow-up care or other services they needed to help them manage their healthcare at home, she points out.

The emergency department staff are trying to process patients so quickly, they don't really have the time or the expertise to connect patients with post-discharge services, but social workers and case managers do, she adds.

High utilizers are challenging for hospitals, and many facilities have ways of identifying them and intervening, Cunningham says. Case managers should be in the emergency department to develop a plan for high utilizers so that whenever they show up at the emergency department, unless they present with something new and different, the staff have a plan in place for connecting the patients with the services they need.

"There's a tremendous return on investment when patients have a care plan identified whenever high utilizers present at the emergency department. This cuts down on the amount of time hospital staff have to spend finding resources for the patient," she says.

Determine the criteria for frequent users at your hospital and once they are identified, work with the emergency department physician to develop a care plan. Enter the care plan into your electronic system and set it up so that whenever the patient registers, the plan prints out so the emergency department staff are aware of it. The staff should call in the emergency department case manager or social worker to get involved, depending on the patients' issues and needs.

After the visit, the case manager or social worker should update the care plan and make a follow-up call to the patient.

Many hospitals are building urgent care centers to keep patients out of the emergency department and free up the emergency staff to treat patients who really need care, Cunningham says.

"There is no requirement in EMTALA to treat a patient who is stable. However, all patients must be screened to determine their stability. Many hospitals are beginning to conduct an initial screening and then telling the patient their condition is stable and giving them the choice of going to a primary care provider or staying in the emergency department to be treated and paying for the service," Cunningham says. Many hospitals have a resource book that lists free clinics and other community resources as well as financial counselors to work with patients to see if they meet the criteria for a government payer.

"When patients come in and it's not an emergency, case managers can walk them to a clinic if there's one on-site or help them get an appointment with a primary care provider," Kizziar says. If you triage patients, determine that it's not an emergency, and refer them to a primary care site, it's not a violation of the Emergency Medical Treatment and Labor Act (EMTALA), she points out. "Hospitals have to get over the fear that everybody who presents has to be treated. You can triage them and refer them to a more appropriate setting," she says.

To continue to stay solvent, hospitals also need to start collecting co-pays up front from people who come into the emergency department, Kizziar says. Primary care providers collect co-pays, and there's no reason hospitals shouldn't do the same, she says.

"Care in the emergency department is not an entitlement, contrary to what many people believe.

We have to cover the cost of care, and for that reason, we have to collect co-pays and determine how to approach people without insurance to make some kind of payment," she says.

Keep in mind the old saying "no margin, no mission" and remember that if hospitals don't make money, they'll close their doors. "Hospitals are going broke and closing. Many hospitals are operating in the red. When community hospitals close, people won't have anywhere to go for services," she says.

SOURCES

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It takes data to justify ED case management

Demonstrate a good ROI for case managers

If you want to develop an emergency department case management program or add to the one you already have, you've got to collect hard data to show that the additional staff will benefit the hospital's bottom line.

Hospitals today are experiencing a severe financial squeeze, which means case managers have to prove their value and demonstrate a good return on investment to justify adding staff in the emergency department, says **Jay Kaplan**, MD, FACEP, director of service and operational excellence for CEP America, based in Emeryville, CA, and a member of the board of directors of the American College of Emergency Physicians.

"If case management directors can demonstrate that their hospital is losing money in the emergency department and case managers can affect it positively, the financial people will listen to your argument," adds **B.K. Kizziar**, RN-BC, CCM, CLP, owner of BK & Associates, a Southlake, TX, consulting firm specializing in hospital case management.

This means collecting data, creating detailed reports, and presenting them to the hospital administration including the chief operating officer and the chief financial officer, Kizziar adds. It takes data to demonstrate the value of having case managers in the emergency department, Kizziar points out. "You can't make the case with anecdotal data," she says.

"The bottom line is, people who make decisions about whether to hire staff for the emergency department are financial people, and case managers need to speak to them in a language they understand, and that's dollars," Kizziar says.

Track how much money the hospital is losing on avoidable admissions through the emergency department, whether the patients were social admissions or didn't meet medical necessity criteria, suggests **Beverly Cunningham**, RN, MS, vice president, clinical performance improvement at Medical City Dallas Hospital. Typically, avoidable admissions are one- and two-day stays, she adds.

Document how many patients admitted through the emergency department were later changed to observation status or did not even meet observation criteria and determine how much money was lost on these patients, Cunningham says.

Determine how many patients come into the emergency department who are not considered a true emergency and how they are triaged. If they are treated in the emergency department, add up how much money the hospital loses if they don't have insurance or if the emergency department doesn't collect their co-pay, Kizziar says.

Tally the number of frequent users who have chronic disease and use the emergency room to manage their conditions. Look at how many patients who come to the emergency department are

EXECUTIVE SUMMARY

When it comes to justifying staff in the emergency department, case management directors need to provide financial data, not anecdotal information to the hospital's finance department. Experts recommend the following:
• Track your facility's avoidable admissions and patients admitted in the wrong status and calculate how much reimbursement the hospital lost.
• Collect information on people treated for non-emergent conditions who didn't pay and what the hospital lost.
• Add up the number of frequent utilizers who use the emergency department to manage their chronic conditions and how many could have benefitted from a referral to community services.

back within a week or two with the same complaint and how many of them could have benefitted from being referred to community resources.

Kaplan suggests implementing a pilot project to demonstrate case management savings. Start by identifying a group of patients who are frequent users and getting case management involved in specific interventions for these patients. "If you can show decreased utilization and decreased cost, it demonstrates the value of case management interventions," he says.

Track the decrease in the number of the patients who return to the emergency department within 72 hours and the decreased 30-day medical admission rate for patients treated and discharged from the emergency department.

Look at how many patients are being admitted in a 24-hour period and what times the admissions occur and use that information to determine when a case manager can be the most effective, Kizziar says.

Before you approach management, come up with a specific plan, she adds. Show the potential savings that case managers in the emergency department could generate as well as a specific plan for utilizing the new staff. ■

ED of future must connect patients, services

It's no longer the gate — now it's the front porch

The emergency department is evolving from being the gate of the hospital to being a front porch for the community, a central location where people with healthcare concerns can come and be triaged to the proper venue for care, says **Karen Zander**, RN, MS, CCMAC, FAAN, principal and co-owner of The Center for Case Management in Wellesley, MA.

"The emergency department's mantra used to be 'treat 'em and street 'em,' but now we need to be thinking about options to get patients the healthcare they need from whatever point they enter or access the systems and ensure that they don't require readmissions or revisits to the emergency department after discharge," she says.

Insurance companies, physicians, and some hospitals have programs that try to dissuade people from using the emergency department for their primary care needs, but because of many factors in the U.S. society today, it's almost a lost cause, she says.

Not only is there a shortage of primary care doctors, but many doctors won't take patients who are Medicaid beneficiaries, or those who have no insurance, adds **Jay Kaplan**, MD, FACEP, director of service and operational excellence for CEP America, based in Emeryville, CA, and a member of the board of directors of the American College of Emergency Physicians.

Patients who rely on community clinics for healthcare often experience a delay of several weeks if they are trying to get an appointment, particularly if they're new patients. If they have an acute illness, the only place they can get seen in a timely manner is the emergency department. If they are told to get follow-up care, they often can't get an appointment and end up back in the emergency department.

"The emergency department becomes the de facto primary caregiver for many patients unless they have a case manager to arrange timely follow-up care in another setting where they have more continuity of care," he says.

There's always going to be a need for the emergency department, Zander points out. "We have to get patients to the right level of care, and we should be starting in the emergency department. The emergency department is an integral part of our healthcare system and each of our communities. They should become more a part of the community and be open to the community's changing demographics and healthcare needs, even if people don't need a bed," she says.

Some hospitals are already becoming like "health malls" and locating pharmacies and durable medical equipment stores near their emergency department, she says. Emergency departments are also diversify-

EXECUTIVE SUMMARY

In today's healthcare system, emergency departments can no longer be a gateway to the hospital. They must be a place where people can be triaged to the proper venue for care, says **Karen Zander**, RN, MS, CCMAC, FAAN, principal and co-owner of The Center for Case Management in Wellesley, MA.

- Patients are going to continue using the emergency department for primary care because of a shortage of primary care providers, making it difficult to get timely appointments.
- Many primary care practices will not take Medicaid recipients, leaving those patients no alternative for treatment besides the emergency department.
- Hospitals need to be able to connect patients to services such as home health and durable medical equipment and to help them get follow-up appointments.

ing into specialty emergency departments, such as those for senior care, pediatrics, and case management services for the complexly ill who have both mental and physical health problems, she says. "They are currently the fastest-changing parts of acute care," she adds.

Zander envisions hospitals having home care representatives, physical therapists, life care planners, health coaches and financial planners located in or near the emergency department to assist patients who do not qualify for acute care but have other needs.

"We need to redefine the hospital as the health and health information source, not just a place for acute care. In the future, hospitals are not going to be able to fill their beds with acute patients because at the rate that change is occurring, many won't meet admission criteria. Hospitals need to continue to create and lobby for services that help people in their communities recover and stay at their highest level of wellness, and that are reimbursed," she says.

People who frequently visit the emergency department often do so because they have nowhere else to go, Kaplan says. "Sometimes people come to the emergency department because of social issues. If we consider alcohol and substance abuse an illness, they are as sick as someone who has pneumonia," he says.

The emergency department has to be considered an integral part of the medical neighborhood, Kaplan says. "We have to look beyond just efficiency of care and the flow of patients within the hospital setting and whether to admit or treat and discharge. We also have to look at the appropriate hand-off in care," he says.

Sometimes emergency department physicians get caught between a rock and a hard place when it comes to admitting patients who can't be safely discharged and who lack other options, Kaplan says. He tells of a 91-year-old woman whose caregiver had resigned and left her with nobody to help her take care of herself. When she came to the emergency department the first time, the physician found out she was alone at home and referred her to social work. The referral fell through the cracks and she came back two days later and ultimately was admitted for a urinary tract infection. "She could have been treated as an outpatient if she had someone to help her care for herself, but with no one at home, she had to be in the hospital," he says.

"We perceive the emergency department is not just the door to the hospital but it's also the porch — the place where people come and sit a bit until they are pointed in the right direction," Kaplan says. ■

CMS continues to shift emphasis to quality of care

Complete documentation is essential

The final rule for the fiscal 2013 Inpatient Prospective Payment System (IPPS), effective Oct. 1, 2012, continues the Centers for Medicare & Medicaid Services' (CMS) move to tie reimbursement to quality, rather than merely quantity, and makes it more important than ever for case managers to ensure that documentation in the medical record is complete and clearly reflects the patient's severity of illness, says **Susan Wallace**, MEd RHIA, CCS, CDIP, CCDS, director of compliance/inpatient consultant for Administrative Consultant Service, LLC, a healthcare consulting firm based in Shawnee, OK.

In the final rule, CMS announced a 2.3% increase in reimbursement for hospitals that participate in the Inpatient Quality Reporting Program and reiterated its intention to add more risk-adjusted measures to the readmission reduction and value-based purchasing initiatives. In fiscal 2013, CMS begins adjusting hospital reimbursement based on their performance on both initiatives.

Beginning October 1, hospitals with excessive readmissions within 30 days for patients with

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services' (CMS) Inpatient Prospective Payment System final rule for 2013 makes it clear that in the future, hospital reimbursement is going to hinge even more on the quality of care patients receive.

- CMS announced its intentions to add more risk-adjusted measures to the reimbursement reduction and value-based purchasing initiatives in future years, penalizing hospitals that do not do as well as their peers on these measures.
- Case managers must make sure that patients are in the appropriate level of care and that documentation clearly reflects how sick patients are and the care they receive.
- Even though some measures won't be added to value-based purchasing until fiscal 2015, the performance period starts as early as Oct. 1, 2012, making it imperative for hospitals to make improvements now.

heart failure, pneumonia, and acute myocardial infarction may have their reimbursement for all discharges reduced by as much as 1%. In addition, beginning October 1, under value-based purchasing, hospitals' base operating DRG payment will be reduced by 1% for each Medicare discharge. Hospitals that perform well on quality measures chosen by CMS or improve their baseline performance on the measures during a performance period will receive value-based incentive payments, beginning in January 2013.

Penalties in the readmission reduction program escalate to 2% in fiscal 2014 and 3% in fiscal 2015. The reductions in base operating DRG payments under value-based purchasing increase by 0.25% annually until reaching 2% in 2017.

The measures on which CMS will base reimbursement in the future are only going to increase, Wallace points out, adding that to ensure their hospitals' success in the future, case managers need to make sure that every patient receives evidence-based care and that the quality data submitted to CMS are accurate and timely.

The biggest impact that the final rule is likely to have on case managers is the risk-adjusted measures being added to the value-based purchasing and readmission reduction programs in the future, Wallace says.

"Because some of these measures will not be added until 2015, people may think that they don't have to worry about them right now. However, the baseline periods for the new measures closed in 2011 and the performance periods begin as early as Oct. 1, 2012, depending on the measures," she adds.

CMS announced that it is adding four new measures to value-based purchasing in 2014, including post-operative urinary catheter removal on post-operative day one or two, and 30-day mortality for heart failure, pneumonia, and acute myocardial infarction. Additions to the list in 2015 include a composite complication/patient safety measure, central line-associated blood stream infections and Medicare-spending-per-beneficiary which aggregates all Medicare Part A and Part B spending on a patient beginning three days before admissions and continuing until 30 days after discharge.

CMS noted in the final rule that it has the authority to add more measures to the readmission reduction program in fiscal 2015 but did not indicate whether it would add more measures or what measures might be added. People who commented on the proposed rule suggested including atrial fibrillation, chronic obstructive pulmonary disease, coronary artery bypass graft, and percutaneous transluminal coronary angioplasty to the list. CMS merely indicated that it would take the comments into consideration when it addresses expansion of the applicable conditions, Wallace says.

CMS also added two new measures to its list of hospital-acquired conditions. They are surgical-site infections following cardiac implantable electronic device procedures and iatrogenic pneumothorax with venous catheterization.

The Inpatient Quality Reporting Program, the hospital-acquired conditions program, and the Value-based Purchasing Program are all based on inpatient admissions, making it essential that patients are in the appropriate level of care at the appropriate time and that their admission status is clearly documented, she adds.

"Documentation can have a big impact on the hospital's payments under the value-based purchasing initiative and the readmissions reduction program. Case managers should make sure the record clearly documents how sick patients are and appropriately identifies the reason they are admitted as inpatients," she says.

SOURCE

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Hospitals collaborate to reduce ED overuse

Initiative slashes ED visits, costs

By collaborating on a case management program for uninsured and underinsured patients who overuse the emergency department, two hospitals in Lincoln, NE, have reduced the number of emergency department visits by patients in the program by 56% and cut emergency department costs related to non-emergent care by 67%. In 2011, the initiative saved the two hospitals about $700,000 in uncompensated care costs.

After a 2002 study determined that 36% of patients who used the emergency department at BryanLGH Medical Center could have been better served in the primary care setting, the hospital applied for a grant from the Community Health Endowment, a local organization that funds healthcare improvements in Lincoln.

The organization approved the grant but stipulated that BryanLGH Medical Center collaborate with St. Elizabeth Regional Medical Center to develop the program. After two years of planning, ED Connections began in 2005, says **Tom Hoover**, RN, MBA, manager of ED Connections. The funding from the grants has ended, but the hospitals have continued to fund the program because it saves enough money to more than pay for itself, Hoover says. The hospitals adapted the Pathways model, which connects at-risk patients to community-based health and social services through the use of pathways designed to produce healthy outcomes.[1]

The ED Connections staff include Hoover, another RN case manager, and two social workers. One nurse and one social worker are located in offices at each hospital. The ED Connections staff at both hospitals share information and all are cross-trained to work at both hospitals. The entire team meets once a month, reviews the cases, and brainstorms about how to handle the difficult ones.

The majority of patients in the program are women ages 25 to 45 with household incomes below the federal poverty level. The patients have no healthcare coverage because they are either homeless or the working poor. Many have mental health and/or substance abuse problems in addition to physical ailments.

Initially, patients eligible for the program were those who had three or more emergency department visits in six months. "This was shooting ourselves in the foot because if patients couldn't afford their medication, they had to have two more visits because we could intervene and by the third visit, they were so sick, they were in crisis," Hoover says.

Now when patients being treated in the emergency department say they can't afford their medication or have difficulties managing their healthcare, the nurse gives them a card with a telephone number for the ED Connections program as part of their discharge instructions. "There are a lot of requirements for prescription assistance as well as other assistance programs and to do it in the emergency department, it takes up bed space and a lot of time for the clinical staff. By having them call us, we get them to take the first step in becoming responsible for their own healthcare," he says.

The team also gets referrals from community agencies, primary care clinics, and emergency department physicians who place an order for a referral in the electronic medical records.

Identifying patients for the program and setting them up with a medical home is the easy part, Hoover says. "Anybody can help a patient find a medical home and make an appointment. The hard part is overcoming all the baggage they carry with them to prevent them from receiving treatment in a medical home," he adds.

When patients call, the ED Connections staff help them get assistance for their medication or other needed items to care for the acute or chronic condition that brought them to the emergency department. At the same time, staff try to get them to enroll in the program. It's a voluntary program and many patients are not interested in participating, Hoover says.

Once patients agree to enroll in the program, the staff conduct a thorough psychosocial assessment to determine needs and work with the patient to develop an action plan and goals. The patient signs an agreement to comply with the action plan, keep appointments, and become an active participant in his or her healthcare. The team also comes up with a specific plan for the emergency department staff to use when patients present to the emergency department.

The team works closely with the patients, educates them on their chronic illnesses and how to manage them, and helps them get connected to a primary care provider and community resources such as transportation assistance and help with rent or utilities. Everyone on the ED Connections staff is a Social Security disability trained worker for behavioral health. The team has a 93% success rate in getting disability claims approved.

A lot of the contacts are over the telephone, but the staff meet with patients at their physician clinic, at home, or when they come into the ED Connection office at each hospital. "We want them to be responsible and try to get them to come to our office whenever possible," he says.

To provide care for patients with behavioral health

EXECUTIVE SUMMARY

ED Connections, a joint project of two competing hospitals in Lincoln, NE, has reduced the number of emergency visits by uninsured and underinsured frequent users by 56%, saving the two hospitals about $700,000 in uncompensated care costs.

- When patients being treated in the emergency department say they can't afford their medication or have other needs, they receive a card with the ED Connections phone number that they can call for help.
- When patients enroll in the program, staff conduct a psychosocial assessment and work with them to create an action plan and goals.
- The team works closely with patients to help them follow their plan of care.

and substance abuse issues, the ED Connections team uses cluster-based planning and outcomes management[2] which divides the patients into subsets, based on their diagnoses. "We wanted to have a common language among providers since one person's definition of mental health problems often is different from others' definitions, making it extremely confusing for patients and providers," Hoover says.

For instance, adults with serious substance abuse, mental health, and community living problems are grouped into Cluster 2A. If the team is dealing with a homeless, bipolar person who is a substance abuser, the patient would be designated as being in Cluster 2A. "Everybody who works with this patient know what Cluster 2A means, the treatment plan, and the outcomes expectations," he says.

About 75% of patients in the program fit into one of the eight adult clusters.

The team has collaborated with 74 different community service organizations in the Lincoln area to provide resources for patients in the program.

"What we are doing could not happen if not for collaboration between competing hospitals, competing clinics, and competing human services organizations. The initiative has opened up a lot of collaborative programs, not just within the hospitals but in the communities," he says.

SOURCE

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1. For more information on the Pathways Model, see http://www.chap-ohio.net/press/wp-content/uploads/2010/09/PathwaysManual1.pdf
2. For more information on cluster-based planning, see the website of Synthesis Inc. and click on Synthesis Services, then cluster-based planning: http://www.synthesisincohio.com/ ■

Intensive CM cuts ED visits, hospitalizations

Team helps patients get access to resources

Community Memorial Hospital's Intensive Case Management Program, which connects frequent emergency department users with appropriate community-based services, has decreased emergency department visits by 42% for a cost savings of $157,769, acute care admissions by 44%, saving $370,475, and reduced the average length of stay by 1.2 days for patients in the program at the 250-bed community hospital in Ventura, CA.

Patients in the program have an average age of 44 and have multiple physical illnesses coupled with substance abuse and mental health issues. Many are disabled and receive Medicare benefits. Some are homeless. "These patients are young and very sick and have multiple comorbidities. If we don't get them set up with services that can help them stay out of the hospital, we will pay the price for years, not to mention the price they will pay for a lower quality of life," says **Bonnie Subira**, MSW, director of the Intensive Case Management Program.

The hospital team went beyond just labeling patients as frequent users and analyzed why they continued coming to the emergency department and determined that one of the biggest factors was that patients had no continuity in care.

"They were being seen by a different provider every time they came in and nobody put the pieces together. Our intensive care management team helps patients identify needs and gain access to the requisite resources. They continue to work with service providers, both medical and non-medical, to ensure that all care providers are aware of the services being provided to the patient. They are the constant factor in assuring that the patients get access to the care and services that they need," Subira adds.

The hospital's intensive case management coordinators work Monday through Friday, 8 a.m. to 5 p.m. The intensive case management coordinator position is 1.2 FTE and 48 hours a week. The two coordinators each work two days a week, and both work on Wednesday.

"This gives us a chance to brainstorm on any

EXECUTIVE SUMMARY

The Intensive Case Management Program at Community Memorial Hospital in Ventura, CA, connects frequent emergency department users with community-based services and has cut emergency department visits by 42% and acute care admissions by 44%.
• Patients are young with multiple physical illnesses, substance abuse, and mental health issues.
• Intensive case management coordinators work closely with patients on a treatment plan, help them access community resources, and go with them to physician visits.
• They visit patients in the emergency department and the hospital and revise their treatment plan.

problems we encounter. Having two sets of eyes on a case has been extremely helpful because this is a difficult and frustrating population and we can share ideas," says **Sarah Johnston**, MSW, MPH, intensive case management coordinator.

They provide care coordination and other support for about 90 patients at a time. Patients are identified by a screening tool that assesses emergency department visits, hospital admissions, pain management and psychosocial issues, medical complexity, and insurance and financial information.

When patients are identified for the program, the coordinators sit down with the patients and develop a plan to help them manage their conditions at home. The coordinators educate the patients on available resources in the community and the importance of seeing their primary care provider. "We go beyond education and do whatever is necessary to ensure that they get the care they need. We set appointments for them, go with them to appointments if necessary and act as their advocate. Nobody wants to be sick, but these people have complicated healthcare issues and they need a lot of support and assistance," Johnston says.

The team identifies patients' needs beyond their medical care, including community resources and mental health resources. "We see how connected or unconnected they are and route them back to the right resources," Johnston says.

When patients in the program present to the emergency department, a flag shows up on their medical record and the intensive case management coordinator is alerted. Their goal is to see patients in the program every time they come into the emergency department. "If they come in during a time when we're not at work, we follow up with telephone calls. If we can't get them by phone, we contact the agencies where they are likely to receive services and get in touch with them that way," Johnston says.

The coordinators go to the emergency department and meet with patients face-to-face, says **Carrie Sundberg**, LCSW, intensive case management coordinator. "We go over the care plan that we have developed with the patient, talk about why they came to the emergency department, and how they could have avoided the visit," Sundberg says. They review the discharge plan from the patient's previous visit and determine if the patient has followed up on components of the plan and identify any roadblocks to adherence. "Our goal is to partner with our patients in a way that helps them to have better health and an increased quality of life," Sundberg says.

When patients are hospitalized, the intensive case management coordinators visit them in their hospital rooms and work closely with the unit case managers to develop an effective discharge plan. "If the staff on the floor needs additional support working with the patient or managing behavioral issues, they know they can contact us," Sundberg says.

The intensive case management coordinators contact the primary care physicians to find out what has been happening with patients in the community that may have resulted in the hospital admission and share the information with the hospital treatment team. Shortly before discharge, they meet with the patient and work on changing the care plan, and notify the primary care physician about the hospital stay.

When appropriate, the coordinators convene family meetings that may include the primary care providers and specialists. In some cases, they bring in an interpreter. They educate the family members on the importance of filling prescriptions and helping patients adhere to the treatment plan and make them aware of community resources they can access, Sundberg says.

The intensive case management coordinators work with patients for months or even years at a time until their condition stabilizes. Visits with the patients range from as short as 15 minutes to as long as five hours, depending on the patient's needs. In addition to the face-to-face time, the coordinators spend a lot of time collaborating and coordinating with providers and organizations in the community to assure that the patients get the care they need, Sundberg says.

The team reaches beyond the walls of the hospital and has developed good working relationships with community providers as well as religious organizations, public health agencies, mental health providers, housing assistance programs, and organizations that support the homeless, Johnston adds.

"We want to give these patients the best chance they can have as outpatients. It often takes a long time to get the patients stable but we never give up. When we are successful, it's so sweet," Johnston says.

SOURCE

• **Bonnie Subira**, MSW, Director of the Intensive Case Management Program, Community Memorial Hospital, Ventura, CA. email:bsubira@cmhshealth.org. ■

Program for uninsured cuts ED visits, admissions

Health system creates HMO-like system

Faced with a growing uninsured population, The MetroHealth System in Cleveland created an

HMO-like system in 2010 to provide care for uninsured patients and embedded case managers in the health system's 11 clinics to ensure that uninsured patients get the care they need to avoid emergency department visits and hospitalization.

The case managers embedded in the clinics are hospital employees and work only with uninsured patients. "We pay the case managers' salaries. We can't afford not to because we're going to be providing care for uninsured patients with no reimbursement. By ensuring that they receive better health care, we are helping them stay healthy and avoid emergency department visits and hospitalization," says **Alice Stollenwerk Petrulis**, MD, medical director for care management at the 500-bed MetroHealth Medical Center, a safety net public hospital.

The program has saved the hospital about $18 per member per month for uninsured patients who are in the HMO and reduced utilization by ensuring that patients are treated at the appropriate level of care.

"We know that most of our admissions come from the emergency department. If patients wait until they are very sick to go to the emergency department, they're likely to be admitted. If we help them keep their chronic conditions under control, we can keep them healthy and they'll stay out of the emergency department and the hospital," she says.

Uninsured patients are categorized into five different plans with varying co-pays, depending on their income levels. For instance, patients who are extremely needy, such as the homeless, are in Plan 0. Those whose income is 400% of the federal poverty level are in Plan 400. The patients pay nominal co-pays for office visits and receive a deep discount on surgical procedures. The HMO is open only to Cuyahoga County residents.

The patients in the MetroHealth HMO are assigned to a primary care provider and cannot see a specialist unless their primary care physician refers them. "We require prior authorization similar to commercial payers," Petrulis says. When patients need procedures such as surgery, MRIs, and PET scans, a prior authorization nurse reviews the patients' medical records using Milliman guidelines for medical necessity and contacts Petrulis if they cannot approve the request. Petrulis reviews the case using clinical judgment and to determine whether to approve or deny a request.

When uninsured patients go to the emergency department, the financial department staff get the process of signing them up for the HMO started. Patients cannot have a clinic appointment unless they have insurance or have been rated under the program. When uninsured patients who are not a part of the program try to make a clinic visit, they are advised to sign up for the HMO.

Providers in the health system's satellite clinics refer uninsured patients who have chronic conditions or multiple medical problems to the hospital's case managers embedded in the clinic. The case managers educate the patients on their conditions and treatment plan, help them with applications for medication discount programs, make sure they have follow-up care, and remind them of clinic appointments.

When patients in the program are discharged from the hospital, the case managers make sure they have a follow-up appointment and call them to remind them. ■

EXECUTIVE SUMMARY

MetroHealth Medical Center in Cleveland has saved about $18 per member a month by enrolling uninsured patients in an HMO-like system developed by the health system.

- Patients pay on a sliding scale based on their income.
- Uninsured patients are signed up for the program when they come to the emergency department and cannot have a clinic visit unless they enroll.
- The hospital embeds case managers in the health system's clinic to work with uninsured patients to help them avoid emergency department visits and hospitalizations.

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

- ■ Placing the uninsured in post-acute care
- ■ The burgeoning problem of ED boarding
- ■ How CMs and hospitalists can work together
- ■ Track your patients' Medicare days

CNE QUESTIONS

1. At Medical City Dallas Hospital, remote case managers access the hospital electronic medical record and work with the emergency department physicians to determine the patient status and level of care on admission for medical necessity and patient status. What times do they cover the emergency department?
   A. weekends and holidays
   B. peak hours, seven days a week
   C. 24 hours a day, seven days a week
   D. 8 a.m. to 6 p.m. weekdays

2. According to Susan Wallace, MEd RHIA, CCS, CDIP, CCDS, director of compliance/inpatient consultant for Administrative Consultant Service, LLC, Shawnee, OK, when will the performance period begin for new measures being added to value-based purchasing in 2015?
   A. as early as October 1 this year, depending on the measure
   B. at various times during fiscal 2014, depending on the measure
   C. after Jan. 1, 2013, depending on the measure
   D. The performance periods have already begun.

3. According to Karen Zander, RN, MS, CCMAC, FAAN, principal and co-owner of The Center for Case Management in Wellesley, MA, the fastest-changing parts of acute care are specialty emergency departments such as those for senior care, pediatrics, and case management services for the complexly ill who have both mental and physical health problems.
   A. True
   B. False

4. How long do the intensive case management coordinators at Community Memorial Hospital in Ventura work with patients who are frequent emergency department users?
   A. three to six months
   B. sometimes as long as a year or more
   C. thirty days
   D. sixty days

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.
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