HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

December 2012: Vol. 20, No. 12
Pages 169-180

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Financial Disclosure:
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Make the hospitalist team your new best friends

Work together on documentation, patient throughput

In today's healthcare environment, as payers tighten reimbursement and auditors from Centers for Medicare & Medicaid Services and commercial payers increase their scrutiny of hospital records, hospitals need to ensure that all patients are admitted in the right level of care and that they move through the continuum as quickly and safely as possible.

Much of this responsibility falls on the case managers, and as hospitals create or expand their hospitalist staff, there's a tremendous opportunity for case managers to partner with hospitalists to improve patient care and optimize reimbursement for the hospital.

Hospitalists are more aligned with what case managers are trying to do than community physicians are because the only patients they are treating are those in the hospital, says **Ralph Wuebker**, MD, MBA, chief medical officer for Executive Health Resources, a healthcare consulting firm in Newton Square, PA.

"There is a huge opportunity for case managers and hospitalists to work together. In many hospitals, the hospitalists are seeing the bulk of

EXECUTIVE SUMMARY:
As hospitals create or expand their hospitalist team, case managers have a tremendous opportunity to work closely with them to improve documentation, ensure timely patient care, and improve throughput.
- Create a good working relationship by assigning case managers to work exclusively with the hospitalist team initially and get to know the physicians and their practice patterns.
- Attend multidisciplinary rounds whenever possible and seize the opportunity to teach hospitalists how case managers can help their practice by ensuring that orders are carried out and facilitating discharge.
- Keep in mind that a collaborative relationship takes time, and take advantage of every opportunity to communicate.

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the patients and are uniquely positioned to collaborate with case managers on length of stay and medical necessity criteria," Wuebker says.

Hospitals are pouring resources into cases that are likely to be targeted by auditors. This is the perfect opportunity for case managers and hospitalists to work together to ensure that documentation is accurate and complete, he says.

Now that Medicare's Recovery Audit Contractors (RACs) and other auditors are scrutinizing physician billing, it may help build the hospitalist-case manager relationship a little quicker than in the past because the hospital and the physicians both are at risk, points out **Pat Wilson**, RN, BSN, MBA, case management director at Medical City Dallas.

Medical City has had a hospitalist program for more than 10 years, and over time case managers and social workers have developed a close working relationship with the hospitalist team. *(For a look at how the relationship was developed, see related article on page 172.)*

Hospitalists offer an advantage to case managers as they try to improve patient throughput and documentation because they are in the hospital all the time while physicians and surgeons make rounds once or twice a day and may not be easily reached by telephone when they are in their offices, says **Linda Sallee**, MS, RN, CMAC, ACM, IQCI, director for Huron Healthcare, headquartered in Chicago.

"If case managers have a good relationship with the hospitalists, they can work together to move patients along," she adds. For instance, hospitalists may have a tendency to concentrate on the new patients and their needs. Case managers may have to prompt them to write discharge orders early in the day, she says.

When case managers and hospitalists work together, it creates the best of all worlds, says **Joel Botler**, MD, a hospitalist at Maine Medical Center, a 500-bed medical center in Portland. At Maine Medical Center, case managers work closely with the hospitalists on determining level of care. They intervene during the course of the hospital stay to ensure that tests and procedures are completed in a timely manner and that the hospitalists are aware of the result.

The case managers and hospitalists hold interdisciplinary rounds every day along with the unit charge nurse or nurse manager and the nurse taking care of the patients. The team also includes physical therapists, occupational therapists, and pharmacy representatives when needed.

"The team discusses the elements of patient care for that day and what will happen in the future. The rounds are a key to improving patient care and throughput," Botler says.

The best model for case management and hospitalist collaboration depends on what works best at the individual hospital, Weubker says. Some hospi-

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

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

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

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

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

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

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

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

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

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tals assign case managers to a particular hospitalist or hospitalist team. In other hospitals, case managers are assigned by unit and may work with several different hospitalists every day.

When case managers are assigned to individual hospitalists, or a hospitalist team, they get to know the physicians and how they practice. As a result, they work closely and collaboratively and provide continuity in care to the patients, says **Patricia Hines**, PhD, RN, vice president of The Camden Group, a Los Angeles-based national healthcare consulting firm.

Maine Medical Center assigned two case managers to the hospitalist group when the hospitalist program began, but that arrangement became unworkable because the case managers had to go with the hospitalists to several different floors each day. Now the case managers and physicians are assigned geographically, Botler says.

Whatever hospitalist-case management model works best in your hospital, it's a good idea to assign new hospitalists to work with an individual case manager for six months or so, says Sallee, who consulted with Maine Medical Center on its hospitalist program. That way, the case managers can help the physicians learn what needs to be accomplished, such as the kind of documentation that is necessary, and the importance of writing discharge orders early in the day.

Wuebker recommends that case management directors meet with a couple of case managers and several hospitalists in small groups so each discipline can get to know each other.

"Many hospitalists simply do not understand what case managers do, but when they do understand it, they welcome the opportunity for collaboration," he says. *(For more tips on working with the hospitalist team, see related article on page 173.)*

Case managers should meet regularly with the hospitalist team during a daily huddle, a weekly team meeting or a hospitalwide meeting—whatever works best in your hospital, Hines recommends.

"When case managers and hospitalists meet regularly and work together, they have an opportunity to learn from each other and build a team esprit de corps. They can learn from each other as they delineate the roles and responsibilities of the entire team," she says.

Whenever possible, case managers should make rounds with hospitalists on a daily basis, adds **Daniel Cusator,** MD, MBA, vice president of physician and hospital operations for The Camden Group.

"You can't overestimate the power of having case managers round with hospitalists if it fits into the hospital work flow. It creates a collaborative team where each member understands what is going on with the other team members," he says. Rounding with hospitalists gives case managers the ability to be more proactive in discharge planning, he adds.

During rounds, case managers have the opportunity to ask the hospitalists early in the stay for information on the kind of resources patients are likely to need after discharge and for suggestions about which types of post-acute facilities can meet patient needs, says **Kerry Weiner**, MD, chief clinical officer at IPC The Hospitalist Company. "Physicians usually have a good idea of what facilities in the area can meet patient needs. They won't know which facilities have beds available, but they can give the case manager a starting point," he says.

At the same time, rounds give the case managers an opportunity to discuss the patient's cultural and religious beliefs, support systems, financial and cognitive issues and how they will impact the discharge plan, Weiner says.

"Many times care plans are designed for optimal situations with open-ended resources and available care givers, but it's rarely the real situation facing most patients. Physicians often don't have the time or even the experience to determine the patient's psychosocial issues, and case managers can help them create a realistic plan. If you don't have the right social situation, it doesn't matter what kind of medication regime or clinical plan you make—it won't be successful," Weiner says.

When a combination of hospitalists and private physicians see patients, it has been effective for the hospitalists to admit patients to a centralized unit, Cusator says. "The hospitalists and case managers can make rounds several times a day and make timely medical decisions," he says.

As hospitals begin to hire hospitalists or expand their hospitalist team, they have an opportunity to benchmark the hospitalists' outcomes against the outcomes of the independent medical staff, Cusator says. Assign case managers to the hospitalist team and measure the impact the team has on cost per day, length of stay, and other key indicators, he suggests. "This will allow hospitals to critically invest in the limited resources that drive improvement," he says. ■

Get to know hospitalists as individuals

It takes patience to build a relationship

The two biggest keys to a good relationship between case managers and hospitalists are to build trust and communicate constantly, says **Pat Wilson**, RN, BSN, MBA, case management director at Medical City Dallas Hospital, where case managers and hospitalists have worked together closely for 10 years.

Building a good relationship takes patience, Wilson points out. Meet the hospitalists where they are and determine how to integrate case management and social work into the way they work on a daily basis.

It's important that the hospitalist team and the case management team understand what both sides do, what their days are like, and what their challenges are, says **Ralph Wuebker**, MD, MBA, chief medical officer for Executive Health Resources, a healthcare consulting firm in Newton Square, PA.

"It's a matter of the case managers helping physicians understand what they do on a day-to-day basis and understanding how the hospitalists work," he says. Let physicians know that the case managers aren't there to criticize or make things difficult for the physicians; their role is to move the patients through the continuum, facilitate post-acute services, and help the hospital avoid losing reimbursement during payer audits, he adds.

Case managers need to get to know about the physicians as individuals and understand what each one needs from the case manager, says **Joel Botler**, MD, hospitalist at Maine Medical Center, a 500-bed medical center in Portland.

"It's crucial for the case managers and hospitalists to get to know each other. If case managers can explain how they can help the physicians on a day-to-day basis, the physicians will be eager to work with them," he says.

It pays big dividends when case managers and physicians can work together as a cohesive team, Botler says.

"At our hospital, it's a rarity for hospitalists to question case managers now. We depend on them tremendously," he says.

Make sure you have the right people in the position initially to build the relationship. Hospitalists at Medical City Dallas told case management leadership that they wanted to work with people who had experience in medical-surgical issues, understood telemetry, and most of all were good communicators, Wilson says.

Include social workers in your relationship with hospitalists, Wilson suggests. "Social workers are key at first because there's not an adversarial feeling about social workers," she says.

Wilson suggests starting by working with hospitalists on unfunded patients. The hospital won't get paid for caring for these patients and neither will the hospitalists. Demonstrate that you can help move them through the continuum and that will help the hospitalists develop confidence in how case managers can help them practice more efficiently.

Case managers should be proactive in seeing patients with the medical staff, whether they are hospitalists or community physicians, instead of waiting until the patient no longer meets criteria to communicate it to the physician, says **Patricia Hines**, PhD, RN, vice president of The Camden Group, a Los Angeles-based national healthcare consulting firm.

"Case managers should begin having conversations with the attending on the day of admission," she suggests. Ask physicians what their plans are for the patient, the patient's anticipated length of stay, and discharge needs. Ask how you can assist in coordinating the delivery of care.

Have ongoing face-to-face conversations with physicians. Don't wait until they have left the floor and call them on the telephone if you have questions or concerns, suggests **Daniel Cusator,** MD, MBA, vice president of physician and hospital operations for The Camden Group.

"In the past, many case managers have not communicated with physicians until there is a denied day or another insurance issue or the patient's length of stay is excessive. This just sets the case manager up for failure when it comes to building relationships," he says.

If patients are being treated by specialists as well as the hospitalist team, case managers should be the liaison between the providers and make sure all of the physicians are aware of the treatment the patients are receiving and agree on the treatment plan, says **Kerry Weiner**, MD, chief clinical officer, IPC The Hospitalist Company.

Keep your written communication short and to the point, Weiner suggests. "Doctors don't have time to read a long note, even if it's typed. In their notes on the chart, case managers should summarize the trigger issues and put the information in

bold or red for emphasis," he says.

Discharge planning should begin when the decision to admit is made, and the sooner the case manager gets involved, the sooner the physician will recognize that he or she is a valuable resource to help manage care, Cusator says.

Involve the executive team in facilitating the case manager-hospitalist relationship, Cusator says. The most significant barrier to creating a good case manager-hospitalist relationship is the perception that the status quo is the way things should be, he says. "People tend to want to keep things the way they have always been. That's why it's critical to have a clear vision of the process that is articulated by whoever is the leader of the initiative, whether it's the chief executive officer, the chief medical officer, or the chief nursing officer," he adds.

In some hospitals, the executive management team may send mixed messages about the role and function of the case management team, Hines says. "In some respects, the case managers' role augments that role of the staff nurses because they are coordinating care throughout the stay and the staff nurse is focused on what happens during a shift," she says.

Hines recommends that hospitalist orientation include education about the role of the case managers and social workers along with the mission and values of the hospital.

"Case managers need to teach the hospitalists that their goal is to ensure that patients get the right care at the right time and in the right place. When both get together and communicate, it can be a very successful partnership," she says. ■

CM-hospitalist relationship took time

Efforts started with education

When Medical City Dallas Hospital began its hospitalist program more than 10 years ago, the hospitalists' average length of stay was within two days of the geometric mean length of stay. Now it's within a half a day.

"This is a significant reduction in length of stay, but it didn't happen overnight. Our hospitalist-case manager relationship has evolved over the years, and it continues to evolve based on the needs of the hospital and the patients and the role of the case managers," says **Pat Wilson**, RN, BSN, MBA, case management director. Hospitalists at Medical City Dallas see the bulk of the medical patients.

Before the hospitalist program started, the hospital's case management leadership worked closely with the director of the hospitalist program to find out the hospitalist team's understanding of the roles of case managers and social workers and their expectations for working as a team. "We found out that the hospitalists perceive social workers as a good thing, but we found that we had to do a lot of education about case managers, their role, and how they can help the hospitalist team," she says.

The case management team started the educational processing by saying that the case manager is the clinical liaison between the patient, the family, the insurance company, and the physician, and that the case manager can translate the physician's plan of care to the family, the patient, and the insurance company, she says.

"We emphasized that the case managers are concerned with anything that affects transition in care and can facilitate the physician's orders," she says. For instance, the case management team explained that if a physician is waiting on the results of an MRI to discharge the patient, and the case manager finds it has been delayed, he or she will call radiology to find out what's happening and notify the physician, lightening their load. On the other hand, if a lab draw or another procedure wouldn't help move the patient to the next level of care, the case manager will concentrate on something else, like facilitating the orders for discharge, she says.

The team asked the hospitalists what kind of person they want to work with and how case managers could meet their needs. "They started opening up and said they wanted to work with someone who has expertise in caring for med/surg patients, who knows telemetry, and who is a good communicator," she says. The case management leaders used the information they got from the hospitalists to choose the right social worker and the right case manager to work with the hospitalist team in the beginning.

At first, the case management department assigned a carefully selected case manager and a social worker to work with the hospitalist team and build a good relationship. "In the beginning the social worker was the point person with the hospitalists because she knew the cases from a social perspective and could facilitate discharge plans for patients who were unfunded or had

other discharge needs. As time went on, the hospitalists learned to trust the case managers and to understand that when we look at medical necessity, we're not telling them how to practice medicine but are helping expedite their orders," Wilson says.

About two years later, the role of working with the hospitalists shifted to the unit-based case managers and social workers. "Once the case manager and social worker assigned to the hospitalist team proved their value to the physicians, it was easy to translate that relationship to any case manager or social worker," she says.

In addition to working with them on the unit, the case managers and social workers met with the hospitalist team weekly to talk about patient needs, barriers to discharge, and to share information on patient delays.

Before the weekly meetings, the social worker and case managers reviewed the patients on the unit and brought up the unfunded patients and those with complex medical or social needs and issuance issues for discussion.

"The weekly conferences were a good way for the hospitalists to get to know the case managers and social workers they would be working with. They'd seen them on the unit and worked with them occasionally but hadn't worked closely with them," she says.

Once the hospitalists developed the same kind of trusting relationship with all of the case managers and social workers, the case management team moved to quick daily huddles between the hospitalists, the case managers and social workers on the unit. During the meetings, they look at every unfunded patient. The case manager talks about the clinical length of stay and the plan of care. The social workers identify barriers to the plan of care. When appropriate the team pulls in physical therapy or other ancillary services to the meeting.

If the hospitalists are admitting patients through the emergency department and recognize that the patient has complex social or clinical issues, they often contact the case manager or the social worker on the unit to which the patient is being admitted and alert them ahead of time that the patient is coming in.

"There's constant communication between the case managers, the social workers, and the hospitalists," Wilson says. For instance, if a patient is waiting for post-acute placement, the social worker keeps the hospitalist informed when a bed is available. The case managers alert the hospitalists if there are insurance issues.

"Our hospitalists truly understand medical necessity because from the beginning, we talked about the role and we continually provide education on the subject. They understand that we apply InterQual criteria and that when patients don't really need to be in the hospital, it's poor utilization of resources whether it's the hospital's or the physician's. We have truly developed a good relationship that benefits the patients, the clinical team, and the hospital," she says.

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Hospital at Home helps improve patient flow

Patients receive services at home

Presbyterian Healthcare Services' Hospital at Home program, which provides acute care services in the homes of patients who might otherwise be hospitalized, has improved patient satisfaction and cut the cost of hospital care by about 30% for the Albuquerque, NM-based integrated healthcare delivery system. The average length of stay for patients in the program is 3.5 days compared to 5 days in the hospital for patients with the same diagnoses.

The program is based on a care model developed at Johns Hopkins Medical Center by Bruce Leff, MD, and focuses on patients with heart failure, chronic obstructive pulmonary disease, complicated urinary tract infections, community-acquired pneumonia, cellulitis, dehydration, nausea and vomiting, stable pulmonary embolism, and deep venous thrombosis, says **Karen Thompson**, OTR, CCM, director of hospice and the Hospital at Home program for Presbyterian Home Healthcare Services.

"The patients in this program are stable but still

need medical care. This is not a substitute for home care. It's a substitute for hospital care," Thompson says.

To be eligible for the program, patients must be insured by Presbyterian Healthcare and live within 25 miles of one of the three hospitals in the Presbyterian system. They are referred by the staff on the hospital's acute care unit, the emergency department providers, their primary care physicians, urgent care centers, and home health care. They are assessed by physicians in the Hospital at Home program who screen the patients for medical conditions, as well as their functional capabilities, and their support system at home.

Patients in the program tend to recover faster than patients who remain in the hospital because they are in a familiar environment, says **Melanie Van Amsterdam**, MD, an internist and one of the physicians in the Hospital at Home program.

"They have a lower instance of hospital-acquired infections, fewer falls, and less delirium. Patient satisfaction is really high and the program helps with patient throughput," Van Amsterdam says.

The program is staffed by two full-time physicians and one full-time advanced clinical nurse specialist, who are on call 24 hours a day, seven days a week and who work with Presbyterian Home Healthcare's staff of nurses and home health aides to provide in-home care for the patients in the program. In addition, a patient care manager, who is a registered nurse, is the direct supervisor of nurses and home health aides and assists the physicians in assessing the patients to determine if they are appropriate for the program. When needed, the patient care manager also visits patients in their homes. The team also includes customer service representatives who verify coverage, arrange for post-hospital services, and get the patients' prescriptions filled before they leave the hospital.

When appropriate, the home care agency's physical therapist, occupational therapists, and speech therapists visit the patients, although most patients do not start rehabilitation while they are in the Hospital at Home program. Many of the patients transition to home care after they are discharged from Hospital at Home.

"Patients don't have to be totally independent to participate in the program, but they do need to be able to go to the bathroom and get their meals, or have a caregiver in the home. If we feel the patient is appropriate for the program and the emergency department provider or the hospitalist agrees, the patient care manager or physician describes the program to the patient and family and offers them the option of receiving healthcare services at home or remaining in the hospital," Thompson says.

Before the patient leaves the hospital, the team arranges for needed equipment and services, such as oxygen or infusion, and gets patients' prescriptions filled through the hospital pharmacy so they can go home with their medication. The hospital staff give patients their next dose of medication so they will have time to get home and get settled before having to take more medication.

After the patients get home, they are visited by a nurse within an hour. Then a physician visits once a day and nurses come to the home twice a day if it is clinically needed. Patients' vital signs and key clinical indicators are closely monitored. When the patients are getting close to being discharged from the program, the nurse may visit only once a day.

"The program is a win-win situation for everyone. Patients like the program because they can recuperate at home, instead of the hospital. The health plan can be sure that their members receive better care delivered at a lower cost, and it improves patient flow by freeing up beds for other patients, something that is very important in the respiratory infection season when the hospital is often at capacity," Van Amsterdam says. ■

EXECUTIVE SUMMARY

Presbyterian Healthcare's program to provide acute services in the homes of patients with stable conditions that otherwise would mean hospitalization has cut the cost of hospital care by 30% and the length of stay by 1.5 days for patients with the same diagnoses.

- Patients must be insured by Presbyterian Healthcare and live within 25 miles of a hospital in the system.
- Patients are referred by hospital and community providers and assessed by physicians in the Hospital at Home program.
- They receive daily home visits by nurses, physicians, and home health aides.

Consider palliative care, hospice as options

Start engaging MDs, family early in the hospital stay

Case managers have the opportunity to provide valuable assistance to their patients who

EXECUTIVE SUMMARY

Case managers can provide a valuable service for patients with frequent admissions for advanced chronic illness or who have end-of-life needs by early referrals for hospice and palliative care evaluations.

- Learn about palliative care and hospice options and educate patients and families to help them make choices.
- Make sure the family is capable of taking care of patients' needs if they are discharged to home.
- Monitor the caregivers to determine if they need extra support or respite services.

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are frequently readmitted to the hospital with advanced chronic illnesses or who are approaching end of life, says **Jennie Roberts**, RN, CCM, MBA, chief nursing officer for Evercare Hospice and Palliative Care, based in Minneapolis, which provides hospice and palliative care services throughout the country.

"When patients are chronically ill or dying, we have one chance to do it right. Palliative care and hospice services are just another way of making sure patients get the right care at the right time," Roberts says.

When case managers think a patient may benefit from palliative care and/or hospice care, it's important for them to start engaging the physicians and talking to the family early in the hospital stay, Roberts says. "It's critical for case managers to develop close relationships with patients and families and to encourage open communication so the treatment team and the family can work together to come up with the best plan of care," she says.

Look at the discharge plan to determine if all the patient's options are included and approach the physician about how a palliative care or hospice consultation might fit, she suggests.

Referrals to palliative care are a good first step in a discussion of end-of-life care, Roberts says. "Palliative care is appropriate at every stage of advanced chronic illness. The palliative care team sees patients as they consider the options to transition from curative treatment to hospice and can provide valuable assistance," she says.

Palliative care is appropriate for patients with frequent readmissions for respiratory or cardiac issues, patients on ventilators, patients with advanced metastatic cancer, patients with combined dementia, and those with sepsis, recurrent urinary tract infections, or any patient with uncontrolled pain.

"It's important for patients and families to understand what palliative care is and that palliative care doesn't signal the end of life but can be implemented while curative treatment options occur. In addition, they need to know that in some cases, palliative care can reduce symptoms and have an impact on improved outcomes," Roberts says.

She suggests that case managers familiarize themselves with the palliative care process so they will be prepared to discuss options with the patient and family members. She recommends The Center to Advance Palliative Care (www.capc.org) as a good resource for a definition of palliative care and other tools to educate and guide healthcare professionals.

When you have the initial discussion with patients, focus on their care goals and their personal goals and wishes as they consider palliative care options. "By listening to patient wants and needs, case managers can more effectively discuss the conditions, the diagnosis, and treatment options to help meet individual needs, including palliative care. Patients and family members need to understand what will happen in the future and all of their options so they can make informed decisions," she says.

Helping families choose care options has three key elements, Roberts says:

- Understand the immediate needs of the patient and family from the clinical perspective, including symptom and pain management.
- Evaluate and understand the psychological and social support of the family and caregivers.
- Develop an action plan and monitor how it is working.

If the patient plans to leave the hospital, make sure the caregiver is ready to take care of all of the patient's needs at home. Educate the caregivers and have them demonstrate what they need to do before the patient goes home.

Give caregivers information on what to expect next and practical suggestions of what to do when something happens. Make sure they understand that if they have problems, they can call someone for help.

Make sure the patients have access to medical supplies and equipment as well as follow-up care after discharge. If pain medication and equipment don't arrive in a timely manner, it could result in a hospital readmission, she says.

Caregivers and patients need a lifeline to someone such as a case manager to answer questions after the patient is home. Caregivers may believe

that they can take care of the patient; however, the care needs may seem overwhelming once they get home. They may need someone to answer their questions or reassure them as they take on the day-to-day activities of caring for the patient.

"Caregivers need to understand that it's OK to call for help if they are not certain about something, and they should have a number to call," she says.

Check with the patient and caregivers after discharge to make sure everything is going smoothly and answer any questions. Monitor the caregivers regularly for the potential of burnout and the need for respite care.

"Support is critical. Case managers need to assess and understand what the patient and caregiver are capable of doing. Caregivers have a huge impact on patient outcomes," she says.

An interdisciplinary team at Evercare Hospice and Palliative Care provides services to patients and families and includes nurses, chaplains, social workers, and hospice aides.

The team sees patients in the hospital as well as in the home setting, skilled nursing facilities, or assisted living facilities. They collaborate with the hospital case managers and discharge planners to develop a plan of care that includes patient and family support and resources. They continue to support the patient and family through the entire episode of care. ■

AMBULATORY CARE *Quarterly*

ED-based hospitalist team helps cut boarding

Success depends on strong cooperation

One of the problems associated with the boarding of admitted patients in the ED is that the practice inevitably leads to increased diversion when the ED's capacity to care for new patients is diminished. This is precisely the problem that Denver Health Medical Center (DHMC) in Colorado was dealing with in 2009. Too often, incoming emergency patients had to be diverted to other hospitals because the ED was backed up with boarded patients. And every hour on diversion was costing the hospital an estimated $5,000 in revenue.

Administrators were determined not only to reduce the amount of time the ED spent on diversion, but also to ensure that patients who were boarded in the ED were well cared for. The solution they came up with was the creation of an ED-based hospital medical team (HMED) that could divide its time between working with nursing supervisors to appropriately manage patient flow while also taking charge of the care of admitted patients who were still awaiting inpatient beds.

In a study that compared the results of this intervention, measured from Aug. 1, 2009, to June 30, 2010, to a control period when the HMED team was not in place, from Aug. 1, 2008, to June 30, 2009, investigators found that the HMED approach made a significant 27% dent in diversion, tied to lack of bed capacity. Also, discharges of admitted patients from the ED increased by 61% during the intervention period when compared to the control period.[1]

Researchers note that patient characteristics and ED volume were statistically similar during the control and intervention periods. The ED saw approximately 50,000 patients during the years, including both the pre- and post-intervention periods, explains **Smitha Chadaga**, MD, the lead author of the study, and associate chief, Division of Hospital Medicine, DHMC.

Involve stakeholders in a trial

Chadaga explains that the idea for an HMED team grew out of a four-day "rapid improvement experiment," one of the Toyota Lean processes that DHMC utilizes when it endeavors to make improvements. "We had emergency department physicians, hospital physicians, utilization management, social work, nursing, and we even had some people involved who didn't have any stake in the outcome just to provide some objective opinions," she recalls. "This solution was devised using input from everyone in the group so, therefore, a lot of the issues that would normally crop up, just in terms of territory or job descriptions, were ironed out during the experiment."

Each person who took part in the experiment then had the task of going back to his or her work environment to report, and then the intervention was deployed, notes Chadaga.

"The hospital medicine team is made up of a

dedicated attending hospitalist and a dedicated allied health professional [AHP]," she says. "During the day shift, from 7 a.m. to 5 p.m., the hospitalist and the AHP are housed in the ED, but during the swing and night hours, the hospitalists on those shifts are covering the entire hospital, but the responsibilities of the HMED team are rolled into those duties."

What was required on the part of the ED to accommodate the HMED team? "The first piece of it was real estate. We built this ED with a nine-bed unit that we called a flex unit with the idea that it could be used for observation or for overflow or for surge capacity," explains **Lee Shockley**, MD, FACEP, clinical director of Emergency Medical Services at DHMC, and co-author of the HMED study. "We have repurposed that and made it essentially an inpatient unit in the ED to be run by the hospitalists, so we did lose nine beds of our capacity in the ED, but what we gained from it was the ability to keep boarded and observed patients in the same location."

There was virtually no resistance to the HMED team because the intervention was rolled out first on a trial basis to see if it would work, explains Shockley. "People were happy to give it a try," he says.

Consider patient care and patient flow

As a level 1 trauma center, there are times when DHMC runs at capacity and the medical floors cannot accept any more patients, observes Chadaga. "In those instances, admitted patients are housed in the ED and the HMED team provides ongoing care to these patients."

Chadaga notes that the HMED team spends about 75% of its time providing patient care to admitted patients in the ED. The team then devotes the remaining 25% of its time to optimizing patient flow. "We have access to the bed board and we work with our nursing supervisors to help get patients to the right floors the first time, especially when patients are boarding in the ED," she says. This is important, notes Chadaga, because in the past, nursing supervisors only had a patient's place in the queue as a guide for when to put patients on an inpatient floor.

"If a patient was in the ED the longest, that patient got put on the inpatient floor first, but patients who have been in the ED for the longest period of time have the greatest likelihood of being discharged," she explains. "Working with the HMED team, which is primarily taking care of admitted patients, we are able to better communicate who is ill and who is closer to discharge. This prevents people from going upstairs to the medical floors only to be discharged shortly thereafter."

Streamline the bed-designation process

From an operations standpoint, the clock starts ticking whenever the ED makes a request for a bed. "If the patient has not been assigned to a floor within an hour, that patient automatically is eligible to [come under the care of] the HMED team," says Chadaga. "ED staff will call that attending when they are ready to give a report, and unless a bed can be found by working with a nursing supervisor, the patient is then under the purview of the HMED team until the patient is assigned to a hospital floor, and then the HMED team will sign that patient out to the floor team."

While all the hospitalists rotate through the HMED team on the swing or night-time shifts, the responsibility of managing patients in the ED who have already been admitted, rounding on them, and then also admitting new patients represents "somewhat of a skill set," observes Chadaga. "All of our physicians are capable of doing it, but we do have a core group of about nine attendings who rotate through the day-time HMED shift just to develop the relationship with the ED and learn the ins and outs of hospital flow and ED inpatient management."

Shockley agrees that the ability of ED clinicians to establish a strong relationship with hospitalists has driven the success of the HMED team in improving patient flow. "Prior to the HMED team, we would make a determination on where a patient needed to be admitted, an admit form would go in, and there was typically a delay before we had a chance to communicate with the internists on the inpatient side of things," he explains.

Once the inpatient staff were consulted, the patient's destination would often change in a process that typically involved a fair amount of rework, adds Shockley. "Having one person to go through in this hospitalist service really streamlines the entire process where we can talk to one admitting team, and they can help in making determinations on where each patient can best be served," he says. "We work with [the HMED team] very closely. It is frequently a matter of a phone call where we ask if they can step over and take a look at a patient. It is much easier than trying to call someone down [from an

inpatient floor] who has other things he or she is trying to attend to."

Establish close ties with hospitalists

Since the HMED team was first implemented in 2009, the objectives of the service have changed a bit to accommodate a physical expansion that included the construction of an observation unit in February of 2011. "The HMED team is still housed in the ED, but we now take care of patients in the observation unit, as well as patients who are boarding in the ED until a room opens up on a medical floor," explains Chadaga.

The observation unit expands the options available to ED clinical staff, observes Shockley. "We have the ability to not take an inpatient bed, but rather have the patient placed in our observation unit that is part of the ED, run by the hospitalist team," he says. "It makes transport a lot easier, and it makes disposition a bit easier."

While the HMED team has been a good fit for DHMC, Chadaga stresses that this doesn't necessarily mean it would work well in all ED settings where there are problems with throughput. "I think it depends on what your issues are. If ED physicians have questions about which service to send patients to, then perhaps establishing a full-consultation relationship with hospitalists could speed up flow. If the issue is that there is a lack of communication about which beds are open upstairs, perhaps opening up more dialog between nursing supervisors and hospitalists might work," she explains. "But if you have a lot of boarded patients in the ED who need care, then actually physically [having a hospitalist] located in the ED can work."

There are many different components to patient flow, observes Chadaga. She adds that the success of any particular intervention will depend on staffing levels, an ED's specific needs, and support from the institution. Another factor that can impact effectiveness is satisfaction with an intervention among clinical and administrative staff.

At DHMC, anonymous surveys were distributed to both nursing supervisors and ED attendings one year after the HMED team was introduced. Results showed 87% of respondents felt that the intervention delivered a positive impact on clinical care for boarded patients, communication, and patient throughput.

The one critical requirement to making an HMED team intervention successful is commitment from both the hospitalists and the ED physicians, stresses Shockley. "You need to have a group of hospitalists who are committed to a project like this and committed to communicating with the ED physicians, and a group of emergency physicians who are accepting of having a hospitalist in their department," he explains. "Everything after that is fairly easy. It is just a matter of finding space available and finding the proper procedures to follow, but the foundation is the relationships."

REFERENCE

1. Chadaga S, Shockley L, Kenison A, et al. Hospitalist-led medicine emergency department team: Associations with throughput, timeliness of patient care, and satisfaction. *Journal of Hospital Medicine* 2012; 7:562-566.

SOURCES

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

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- 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
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- ■ What's new with CMS auditors?
- ■ How to reduce ED boarding
- ■ Focusing care on senior patients
- ■ Discharge planning for unfunded patients

CNE QUESTIONS

1. **Linda Sallee**, MS, RN, CMAC, ACM, IQCI, director for Huron Healthcare, recommends assigning new hospitalists to work with an individual case manager for about six months.
   A. True
   B. False

2. According to **Pat Wilson**, to develop a good working relationship with hospitalists, which patients should you tackle first?
   A. Those with pending discharges.
   B. Patients who have been readmitted.
   C. Unfunded patients.
   D. Patients with long lengths of stay.

3. How soon does a nurse visit patients who are discharged from the acute care hospital to Presbyterian Health System's Hospital at Home?
   A. Within an hour of discharge.
   B. The day after discharge.
   C. Before they leave the hospital.
   D. Within eight hours of discharge.

4. According to **Jennie Roberts**, RN, CCM, MBA, chief nursing officer for Evercare Hospice and Palliative Care, what should case managers do to help families choose palliative care and hospice options?
   A. Understand the immediate needs of the patient and family, including symptom and pain management.
   B. Evaluate and understand the psychological and social support of family and caregivers.
   C. Develop an action plan and monitor how it's working.
   D. All of the above.

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