HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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Are you tired, overworked? You must be a case manager

Make the case for fewer tasks, more staff

It's been happening for years. The Centers for Medicare & Medicaid Services (CMS) or commercial payers start a new program or ask for additional information and the responsibility is delegated to case management "since they're in the charts anyway." As a result, many case managers are feeling overworked and often can't do their jobs adequately.

Over the years, the caseloads carried by case managers haven't changed, but hospitals have been adding other pieces to the case management workload, says **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY, and partner and consultant in Dallas-based Case Management Concepts. "In order to keep adding more tasks to case management duties, the case manager-patient ratios have got to get smaller. Case management leaders can't keep agreeing to take on more responsibilities. Instead, they should say they can't take on a certain function and suggest a way to cover it," she says.

Case management directors need to make sure that case managers are not so overloaded they can't do their job, says **Teresa C. Fugate**, RN, BBA, CCM, CPHQ, a case management consultant based in

EXECUTIVE SUMMARY

Case managers are being asked to take on more and more tasks, but the caseloads haven't changed, resulting in tired case managers who aren't able to do the job adequately.

- Make sure the hospital administration understands what case managers do and the value they bring to the organization.
- Consider developing specialty positions or adding clerical staff to optimize skill sets for staff.
- Use hard data, not anecdotes, when you make your case to management.

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Knoxville, TN. The problem is that most of the time, case management is thought of as a cost center and not a revenue center, Fugate points out. Administrators don't understand that case management and care coordination are part of the revenue stream, even though the hospital loses revenue if case management tasks aren't done well, she says.

"If hospitals continue to pile task after task on case managers and they carry a heavy caseload, they will fall short because they can't do everything and do it well. When hospitals keep adding things onto case management without determining that the activities are appropriate for case managers, they are setting themselves up for failure," Fugate says.

At the same time case managers face challenges in getting the job done, there are tremendous opportunities for case managers as healthcare changes and Medicare and other payers add more requirements and hospitals look for ways to meet them, Cesta points out.

"Case managers are in a unique position. We are becoming the pivot point for a lot of new things. If there was ever an opportunity to demonstrate the value of case management, it's now," Cesta says.

"With the changes in reimbursement, hospitals are seeking opportunities to become more efficient and decrease the potential for poor reimbursement. Decision-makers and leadership are becoming more open to looking at how best case managers can accomplish their jobs," says **BK Kizziar**, RNC, CCM, CLCP, a case management consultant based in Southlake, TX.

In order to get more staff, case management directors need to be able to show the value the department brings to the organization to the senior leadership, which always has so many competing priorities, says **Denise Majeski**, MSN, RN, ACM, NE-BC, interim chief nurse executive at Northwestern-Lake Forest Hospital, a 201-bed community hospital in Lake Forest, IL, that is part of Northwestern Medical System.

"Hospital management and staff outside the case management department often do not understand the function of case management and the value it brings to the organization. To do so, you need to be able to show what case management does, what the outcomes are, and show the value of adding additional staff. If you don't have a model, a workflow process, and metrics, you won't be successful in proving your value," she adds.

Case managers have not been adept at educating the hospital administration on case management activities and how they affect the bottom line, Fugate says. "Increasing staff is all about revenue. If you can't prove that you can impact the

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quality of care, length of stay, and readmissions, you aren't going to be able to convince management that you need additional staffing," she says.

Case management leaders must market their department's services to leadership, Fugate says. "In this environment, increasing case management staff is going to be a hard sell," Fugate says. For instance, a hospital's loss of money in the CMS readmission reduction program may not be as much as the cost of developing a program to follow patients after discharge, she adds.

On the other hand, when lengths of stay are three to five days at maximum, there are some critical activities that must be done, she adds. "Show where your successes are in reducing length of stay and where failures, such as readmissions, are and include the activities involved and the time it takes to do them. It still will be a hard sell," she says.

Solutions that may be more financially viable than adding more case managers include developing specialty positions that optimize the skill sets for staff, hiring clerical support to handle all the case management tasks that don't require a license, or investing in case management software, Cesta says. "If you go to the administration with a business plan that calls for a ratio of 1 case manager for every 10 patients, the average hospital administrator won't go for that. But if you ask for one specialty position focused on readmissions or three clerical jobs, you may be successful," she says.

For instance, your hospital may have only a few readmissions at a time. That may make it cost-effective to add a readmission reduction or transition case manager who focuses on the problem hospitalwide, she suggests.

"Our hospital has a person who follows at-risk patients for six weeks after discharge. It's remarkable how many problems she has caught and solved," she says.

Another add-on position is a discharge planning specialist who handles complex, time-consuming cases, such as those that involve setting up a guardianship, or finding placement for an undocumented person. "This person could carry a caseload of complex patients and free other staff to manage and move the other 80% of patients through the continuum," Cesta says.

People in a specialty position develop the expertise to perform their job quickly and efficiently, especially when it comes to complex case management, Cesta says. For instance, if a case manager encounters the need to set up a guardianship only once or twice a year, he or she can't do it as quickly as someone who deals with it on a daily basis. "The specialty case manager has the connections and knowledge to do the job, and that can make a huge difference," she says.

Some hospitals have set up resource management centers staffed by clerks and/or LPNs who coordinate referrals and arrange for resources such as home health and social services, Fugate adds.

Make sure that the case management department handles only tasks that are specific to the job description and practice standards of case management, Kizziar says. "When hospitals don't know where to send a responsibility, they are notorious for sending it to case management. Case managers are doing legacy tasks that they have accepted over the years. This has to stop. It significantly limits case managers' ability to be successful when they have responsibility for non-case management duties," she says.

The case management role should include partnering with physicians, managing the cost of care and length of stay, care transitions, and preplanning of transitions to the next level of care, she says.

"I still go to hospitals where case managers do utilization review and social workers are in charge of discharge planning. This worked in the 1980s, but it isn't the best way to do it now. Utilization review is not a unique function of case managers," Kizziar says.

She recommends that hospitals take the utilization review role away from case managers, freeing them up to sit down with patients and families to get the information they need to develop a care plan, and manage the transition to the next level of care.

When the case management team includes the case manager, social worker, and utilization review nurse along with clerical support, the case manager can handle a larger caseload than the case manager who has to do all of those things for each patient, Kizziar says.

It works best for appeals and clinical documentation improvement to be removed from the day-to-day work of case managers, Cesta says. "I see a lot of value in parsing it out. Case managers can't do this and their regular tasks such as care coordination and discharge planning. This is a good place for other specialty positions," she says.

Case managers get a lot of requests to review

denials that are not clinical in nature, Kizziar adds. "These need to be handled in another department. In addition, clinical denials don't necessarily have to be handled by case managers. They can be handled by nurse auditors, particularly if there is an electronic medical record," she says.

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Want more staff? It's all about the data

Do your homework before making request

Before case management directors can make the case for more staff, the hospital leadership has to identify case management as a valued program, and in order to be considered valuable, the case management department has to develop a structure, identify the processes it performs, and be able to speak to its outcomes, says **Denise Majeski**, MSN, RN ACM NE-BC, interim chief nurse executive at Northwestern-Lake Forest Hospital in Lake Forest, IL.

"Case management departments must have clear policies and procedures, including the assignment of staff and a clear orientation process. They should have a way to measure productivity and have staff performance dashboards that align with organization statistics," she says.

Begin by defining your mission and goals, making sure they are aligned with the mission and goals of the organization. Map out the responsibilities of the department, roles of the staff, detailed job descriptions, and department policies and procedures, she says.

"You have to start with a model. Develop a model that includes each function of case management and show that if you have the right staffing mix, the goals of the model can be achieved," she says.

Start by making sure the right roles and functions are assigned to case managers and nurses and that they don't do work outside their scope of knowledge, suggests **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY, and partner and consultant in Dallas-based Case Management Concepts.

Look at the resources you have and make sure they are being deployed appropriately and to the skill set and level of expertise of the people doing the job. Do a gap analysis to determine where you need help. List the activities that case managers do on a day-to-day basis and determine if they are something only a case manager can do or could other staff assist with them, she suggests. Tabulate the time involved and use the information to determine if you have the appropriate staff ratios to cover all the activities, Cesta says.

No magic formulas

There is no magic formula for determining case management caseloads, adds **BK Kizziar**, RNC, CCM, CLCP, a case management consultant based in Southlake, TX. They are based strictly on the responsibility of the case management staff and how the responsibilities are distributed and may differ from hospital to hospital and unit to unit, Kizziar points out.

To determine your optimal caseloads, make a comprehensive list of the responsibilities of case managers and how long it takes in a typical day to meet each element of responsibility, Kizziar says. Determine how many tasks are done in a day and you can determine how many case managers you need to do those tasks.

Look at what the case managers' responsibilities are and ensure that they have the tools to do them. If they are still putting in long hours or not getting the job done, they may be doing tasks that are not case management-related, Kizziar says.

"Your request to management has to be borne out in the data. Anecdotal stories of staff staying late and not getting the work done just don't fly," Kizziar says.

Before you approach management about adding positions, develop a business plan, using a

format that outlines what is needed and why it's needed using objective data, Cesta says. Data is essential. Don't approach the subject from an emotional viewpoint. Chief financial officers relate to data, she adds.

Define the business opportunity, and plan the work effort. Have alternatives in mind when you approach the administration.

For instance, if you want a specialty position to handle complex discharge planning, tally the average number of complex patients who need a significant amount of discharge planning and the average time each case takes. Show how the complex cases slow down the regular case management work by X number of days to demonstrate the need for the position.

Kizziar gives another example: If your initial and concurrent utilization reviews take an average of 12 minutes, come up with the number of utilization reviews the average case manager does in a day. Use that information to show that having dedicated staff doing utilization review can free up case managers to meet with families and prepare them for discharge or collaborating with the nurses to make sure everything is being done to move the patient through the continuum, such as removing the catheter or getting the patient out of bed and ambulating, she says.

To justify other staff, look at how many payer denials your hospital receives that are due to lack of clinical data or how many 30-day readmissions you experience. Tie a dollar amount to the lost revenue and compare it to the cost of redesigning the program or adding staff.

Whenever possible, tie your requests to a dollar figure, suggests **Jenny Prescia**, MSN, RN, ACM, CCDS, interim director of case management for Northwestern-Lake Forest Hospital in Lake Forest, IL.

"Case managers affect quality through the readmission rate, denials, transitions of care, and care coordination, but quality needs to be tied to dollars. Otherwise, it's too easy to say that salaries are too high and cut the department," Prescia says.

For instance, in addition to showing management your denial overturn rate, include a dollar figure on how much you recouped. "This will make an impact in case the leadership is trying to cut costs and sees your department salaries as low-hanging fruit," Prescia says.

When the case management team at Northwestern-Lake Forest wanted to expand to the outpatient side, the team used its dashboard of metrics that showed what case managers do on the inpatient side, how their efforts affect revenue and reduce financial risk, and shared it with the organizational leadership as well the physician leadership.

The department was able to add an outpatient orders management unit staffed by RN case managers who are assisted by highly trained clerks called case order management specialists, Prescia says. The unit reviews every outpatient order for medical necessity and order correctness, performs pre-billing denials management, works closely with physicians, and handles Advance Beneficiary Notices. The outpatient orders management team also covers two outpatient infusion centers and gets preauthorizations for every infusion and reviews every case for medical necessity. Last year, the team achieved an 88% turnover rate for denials.

The outpatient team collaborates with the inpatient case managers on transitions of care and discharge planning. "They work together, looking for the least costly discharge plan. For instance, if patients need infusion services after discharge, they may be able to arrange for the patients to come to the outpatient infusion center rather than having a home health nurse do the infusion at home," she says. ■

Productivity tool measures CM success

It's used for evaluations, to justify more staff

When the case management leadership at Northwestern-Lake Forest Hospital in Lake Forest, IL, wanted to add a position on the acute care unit, they used the productivity/capacity tool they developed to show management how hard the staff on the 44-bed unit were working.

Using the tool, the case management leadership determined that the case managers on the 44-bed acute care unit had a 157% productivity rate when the department target was 95% to 125%.

"We were able to show the data to the chief financial officer and justify hiring a social

worker to help address the complex discharge planning needs of patients on the unit. We hired a full-time social worker, and suddenly the overtime we were paying one of the case managers who is an hourly employee dropped. That, plus avoiding the risk of losing experienced but exhausted case managers more than paid for the social worker's salary," says **Denise Majeski**, MSN, RN ACM, NE-BC, interim chief nurse executive for the 201-bed community hospital.

Developing a capacity and productivity tool is an essential part of proving the value of case management, Majeski says. "The tool assists in staffing budget decisions, supports the FTEs needed for the department, and defends the need for new staff. It justifies the work of the department to the organizational leadership," she adds.

To create a tool, make a detailed list of case management tasks and assign a time to each, says **Jenny Prescia**, MSN, RN, ACM, CCDS, interim director of case management. Prescia shadowed multiple case managers with a stopwatch and measured how long each task took each case manager, then came up with an average time for each task. "Some tasks were cut-and-dried and took about the same time every time but others, such as discharge planning, had varying times depending on the complexity," she says.

Determining productivity

To determine the productivity of an individual case manager, tabulate the number of times the case manager completes each task each day and multiply by the time it takes to complete the task to get a total time spent, and multiply it by the days the tasks were performed. Add the total time for all tasks to determine how many hours the case manager spent working. Divide the number of scheduled hours into the total hours worked to show productivity.

At Northwestern-Lake Forest Hospital, every time case managers complete a task, they enter it into the case management software. Prescia uses the data to create reports that show the productivity of the individual, a unit, or the entire department. "I can run a report that shows how much time each case manager spent on discharge planning or how much the entire department spent and come up with the percentage of the day spent on discharge planning," Prescia says.

When several case managers complained that a per diem social worker wasn't doing her job, an analysis showed that she was operating at only 25% efficiency. When she didn't change after she was put on a performance improvement plan, management suggested that she look elsewhere for a job.

"This tool is objective, not subjective. The staff all know that they are being held to the same standards and there is no favoritism," Majeski says.

The management team uses the tool as part of each employee's annual performance evaluation. "It helps them feel successful. If they aren't meeting their performance goals, instead of saying 'you're not doing your job,' we can ask if they are satisfied with their metrics and suggest that we work together on improving them," Prescia says.

Case managers at Northwestern-Lake Forest are responsible for utilization review, coding and documentation, denials management, discharge planning, and care coordination. "Our model works in a small hospital, but it may seem overwhelming in a larger organization. We've observed that job enjoyment decreases when case managers concentrate on just one job function all day long," she says. In staff satisfaction surveys, 98% of case managers report high job satisfaction and 100% answer "yes" to "I know what is expected of me in my job."

The average caseload, depending on the unit, is 20 to 25. Case managers on the orthopedics unit have an average caseload of 13. On the intensive care unit, it's 15. The surgical case managers have a caseload of 22 to 25. ■

EXECUTIVE SUMMARY

Case management leadership at Northwestern-Lake Forest Hospital has developed a capacity and productivity tool that tracks the work and efficiency of the case management staff.

- The department tabulated the average time it takes case managers to complete each case management task and tracks the time each case manager spends on tasks each day.
- The tool can be used to show the productivity of an individual, a unit, or the entire department.
- Department leadership shares reports with management and uses it in employees' annual evaluations.

Peer interviews, mentors = happy case managers

Hospital system increases staff satisfaction

At Carolinas HealthCare System, case manager candidates are interviewed by their peers, who make the final selection. Then, as part of their training and orientation, they work with a preceptor for at least six weeks and a mentor for a full year.

The program has helped the case management department hire people who will fit into the culture of the organization and has helped the organization retain experienced case managers and have increased employee satisfaction, says **Barbara DeSilva**, MSN, MHA, FACHE, CPM, ACM, vice president of clinical management for the seven-hospital healthcare system with headquarters in Charlotte, NC.

"We have a large, stable workforce and an engaged workforce. Our training and mentoring program also helps us develop leaders. About 80% of the people who rise through the ranks and become managers were staff members in our own department," she says.

When there is an opening, DeSilva selects potential candidates from the pool of applicants. The hospital system requires its case managers to have a four-year degree and a strong clinical background, and preferably have case management experience.

A team of case managers that includes people who will be working with the new employee interviews the candidates one at a time. "We work in small teams at our hospital, and the chemistry between team members is important. The peer interviewing team spends a lot of time with each applicant to make sure they will fit in," she says.

The three-person peer interviewing team includes case managers and social workers, all of whom have gone through a peer interviewing class offered by the health system's employee development department.

They use a set of questions the department has developed as a guideline, describe the job in detail, and encourage the candidates to ask questions. "I want the candidates to get an accurate picture of what the job is like. We give them the opportunity to ask questions about the role and get clarity," DeSilva says.

The team of peers can answer questions about the day-to-day work on the unit, information that management may not know in detail, she adds.

When new case managers begin work, they go through a multi-dimensional educational process that includes classroom time and on-the-job training. They go through the health system's week-long orientation session and then are assigned to a preceptor who works with them as they complete a six-week case management orientation and training program. The preceptors are tenured staff members with good communication skills and good productivity records. The department tries to assign a preceptor who works as closely as possible to the unit where the new case manager is going to work.

The new case managers must demonstrate competency in each of the training modules. For instance, in the utilization review area, they start by reviewing one chart at a time while the preceptor watches. "It is pretty hard for people to get their arms around a role unless they have done it. We tell them that it takes a solid year before they will feel totally comfortable in the job," she says.

Their training includes time in the health system's resource center to learn about insurance, hands-on time to learn the computer system, and InterQual training. In addition to work on the floor, they also spend time with home health to become familiar with the post-acute side.

While orientation and training typically lasts six weeks, it can be extended if the new case manager is struggling. "If people have a passion for the work and are truly trying, they can take as long as they need to. Not everybody is a quick learner," she says.

Then the new employees are assigned to a unit and work closely with the case managers on the unit, starting with one case and gradually taking on a bigger workload as they learn how the unit operates. "We try to place new people on units that are big enough to have two nurses. Case management can be very isolating, and we want the new employees to have someone to work with in

EXECUTIVE SUMMARY

New case managers at Carolinas HealthCare System are chosen by their peers and as part of orientation, work closely with a preceptor, then meet with a mentor for a year.

- Case managers who will be working with the new hire interview candidates and make the final selection.
- The preceptor follows them as they complete the case management training orientation program that includes hands-on training.
- When they start their new job, they are assigned a mentor who meets regularly with them for a year and is available for questions and concerns.

the beginning," DeSilva says.

Once new employees are assigned to a unit, they also are assigned a mentor who may or may not be the preceptor. If they have questions or concerns, they have someone they feel comfortable with to whom they can turn for answers. The mentoring program lasts a year. The new case manager and mentor meet at least once a month, usually more often. "The mentor role is strictly voluntary. We do want experienced case managers, and we try to match the mentor whose personality matches that of the employee," she says.

The management team monitors the work of the new case managers and meets with each unit at least once a week to review the cases. "We want to make sure the new hires are comfortable in the role and happy with the job. We can find out a lot just by talking through the cases," she says.

The health system recently revamped its orientation and training program and developed a new six-week education program.

"We use educational modules to include topics such as short-stays, observation criteria, Medicare Conditions of Participation requirements, and the Recovery Auditors and other auditing programs," she says. ■

Tailor ED discharge plan to the individual

One size just won't fit all

As case managers work with patients in the emergency department, they need to let each patient be the guide in creating a plan that will work, particularly when they coordinate care for patients with low socioeconomic status, says **Shreya Kangovi**, MD, director of the Penn Center for Community Health Workers and a Robert Wood Johnson Foundation Clinical Scholar in the Department of Medicine at the Philadelphia Veterans Affairs Medical Center.

"Case managers need to think outside the box and take a more patient-centered approach instead of a one-size-fits-all plan and develop strategies that meet each patient's individual needs," she says.

Kangovi was lead author in a study at Penn Medicine that examined the reasons low-income people use the emergency department rather than seeking care in a physician's office. Researchers worked with trained community health workers to conduct detailed interviews with 40 Philadelphia patients who were low income and uninsured or Medicaid recipients to find out why they choose to visit the hospital emergency department instead of seeing a primary care physician.

Primary care and preventive care are riddled with barriers that drive patients away and into the emergency department, Kangovi says. Patients told researchers that when they call their primary care providers, the phone is rarely answered by a real person, they often have to wait weeks to see the doctor, and they have to take time off work and line up transportation. Then the primary care provider may send them to one or more specialists and they miss work again, have another co-pay and more transportation issues.

"All of us can relate to the problems with the healthcare system that these people face. The difference is that low-income people don't have the resources to work around the dysfunctional healthcare system. They can't just take a cab or take a day off work with pay or afford the co-pays. They have to wait and use the hospital and receive care that is costly," she says.

Low-income people are not coming in to the emergency department with non-emergent conditions, prior research shows. They tend to come in much sicker than higher-income people, with conditions that could be prevented. For instance, they may come in with an asthma attack that may be life-threatening but could have been be prevented.

"When we talked to the patients themselves, it became very clear that we have to debunk this perception that all we have to do is educate

EXECUTIVE SUMMARY

A study by Penn Medicine that examined why low-income patients seek care in the emergency department concluded that the healthcare system drives patients away from primary care and to the emergency department.

- Low-income patients have to miss work and line up transportation to make a primary care visit.
- Often, their providers are in clinics with a limited number of appointments each day.
- Instead of merely lecturing patients about seeking care at the right level, case managers should develop strategies to meet each patient's individual needs.

patients on the proper use of the healthcare system. Instead, the patients educated us on how the pitfalls to receiving care are caused by the way we have structured the healthcare system," she says.

As healthcare professionals redesign the healthcare system, they should let patients be their guide or the new system also will be broken, Kangovi says.

"Patients are the experts and can tell us how an idea that sounds good in a conference room will play out in real life," she says.

For instance, one of the strategies for patient-centered medical homes is open-access scheduling that allows patients to schedule same-day appointments with primary care providers.

However, low-income patients told the researchers that the idea often won't work for them. They don't have flexible jobs and to take a day off work, they have to schedule an appointment ahead of time. Many receive their care in clinics with few telephone lines and by the time they get through, all the slots are booked. They have to rely on subsidized transportation, and that has to be arranged 72 hours in advance.

"The devil is in the details and the patients should be our guide," she says.

The researchers looked at patterns among low-income patients who use the emergency department for primary care and found two distinct groups, each with a different set of issues. One group has experienced extraordinary trauma in their lives that resulted in social dysfunction and mental illness. For instance, one patient was a child when he came home from school, saw his father being arrested and never saw him again. Another witnessed the murder of a loved one.

Members of the other group report social stability and live in tight-knit communities. However, many of the people they are close to are ill and very poor. "These patients are too busy taking care of others to take care of themselves. They can't take time off work to see a doctor when they get sick because the family relies on their paycheck," she says.

One strategy is to use community health workers, trained lay people who share life experiences with the patients, which makes them natural helpers within the community, she says. "There's a lot of potential for this type of workforce. They have had similar experiences to those the patients face and can develop the rapport needed to figure out patients' needs and the underlying problems," she says. ■

$2.6M more revenue captured with audits

Denials cut to only .08%

Patient access leaders at Florida Hospital in Orlando don't spend much time auditing denied claims, because there simply aren't many of them. The department has a current denial rate of just .08%.

"We began this process in 2002. In that year, we wrote off $4.5 million or .42%," says **Bonnie Hache**, administrative director of patient access. "If we were still at that rate, we would have written off almost $10 million in 2012."

In 2012, the hospital wrote off $1.9 million. "The Healthcare Advisory Board reports hospitals run at an average of .8%. That would represent $18 million for Florida Hospital," says Hache.

Hache credits her department's success to being "very intentional in reviewing why mistakes are made and training our staff. If you don't take the time to do that, you will not improve." The department's "denial avoidance process" includes weekly meetings at which every denial of more than $1,000 is reviewed in detail. "Then, we meet with reps on an individual level so they can figure out what they did wrong," she says.

Staff members stay on top of all changes, such as a recent trend toward payers requiring more clinical information to meet requirements for medical necessity. Many times, an authorization is no longer enough. Payers want to review all the physician's records on the patient to ensure all steps have been taken to avoid a high-cost test.

"Insurance companies are looking much closer at every service we provide and hold us to a much higher standard for obtaining authorizations," says Hache.

Florida Hospital's patient access management and other members of the denial avoidance team routinely round in clinical areas to discuss issues causing denials.

"We are leaders in this area, but it is only by working together," says Hache. "We make sure we are meeting their needs, and we listen to what they say."

Clinical areas openly discuss the challenges they are facing working with physicians, for example. "Their assistance in speaking with physicians regarding services that are not covered is instrumental in making changes," says Hache. Recently,

Hache made clinical areas aware of these reasons for denied claims:

• Some payers require a CT scan to be done before a positron emission tomography (PET) scan will be authorized.

• Some payers require documentation of alternative approaches before authorizing physical therapy, such as taking anti-inflammatories for a specific amount of time.

"We take account-level information back to them," she says. "We share with them what was missed, and discuss what they can provide to us in the future."

Hache doesn't think investment in technology to audit denials would be cost-effective at this point in time, since denials are so few.

The manual process used by the department was very labor-intensive at first, but it is much more manageable due to the low error rate, she reports. "We have no plans to automate this process," she says. "Our denials are so low that to spend a lot of money on technology doesn't make sense," she says.

Last year, "no auth" denials totaled just $250,000. Most of these occurred because of mistakes made by patient access representatives, such as taking the provider's office's word that no authorization was required instead of calling the payer directly.

"Those are mistakes that even technology couldn't help us with. Some human error will occur," she says. ■

Engage family members in crucial conversations

Anyone facing a hospital stay probably has heard the advice: Take someone with you to lend support, ask questions, and serve as a care partner and advocate.

But is the clinical team including this person in crucial conversations? It is important to include the patient's family member or other advocate because that person can help solidify the doctor's relationship with the patient, says **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, LHRM, a patient safety and risk management consultant with The Kicklighter Group in Tamarac, FL, and a past president of the American Society for Healthcare Risk Management (ASHRM).

"If it comes to the point that they're considering legal action, they may not take that step if they feel like they have a good relationship with the doctor and they know that he or she really had the best interests of the patient at heart," she says. "Being inclusive with these conversations is a way to get that bond. If you're talking only with the patient, even if you do it well, later on they might have family members who see the doctor in a different light."

Risk managers should counsel physicians to include family members in crucial conversations, with the patient's permission, suggests **Karen Curtiss**, president of PartnerHealth, a company in Illinois that promotes patient safety.

Curtiss became concerned about family involvement in patient care when a series of medical errors occurred in her family. After a successful lung transplant at a top academic medical center, her father died from complications resulting from a fall that went untreated for 57 hours, which led to pneumonia, blood clots, a pulmonary embolism, and two infections. Her husband spent 18 months recovering from sepsis and an infection, stemming from improper surgery preparation and care afterward. And her young son would have undergone an unnecessary operation had she not questioned a doctor and sought a second opinion.

Determined to help other families avoid similar fates, Curtiss, a consultant with more than 25 years of market research experience, started digging for answers. Curtiss compiled her research into "Safe & Sound in the Hospital," a new handbook designed to educate patients and their families about how to prepare for a hospitalization, stay on top of the many issues that can arise during a hospitalization, and help prevent another hospital stay. The book provides practical tips, creative tools, and quick checklists that care partners can use to help prevent common hospital hazards and promote a safe recovery.

Curtiss suggests that risk managers train clinicians to pass these tips to family members:

• **Keep your loved one safe from infection.**

– Make sure everyone, especially doctors and nurses, washes his or her hands before touching your loved one. Make colorful tent card signs for your loved one's room with messages such as "Thank you for washing your hands!" or "For my safety, please wash your hands."

– Clean TV remotes, door knobs, telephones, bed rails, call buttons, faucets, toilet flush levers, and personal items with alcohol wipes and bleach wipes to help prevent infection. Repeat cleaning after every touch or brush with clothing.

• **Speak up and ask questions.** Get to know everyone who takes care of your loved one. Ask questions in a friendly, respectful way. Don't be afraid to admit

if you don't understand their answers and need a "plain English" translation.

• **Find out how to call for a Rapid Response Team if you feel like your loved one is going downhill and no one seems to be taking action.** Trust your gut; you know your loved one best.

• **Ask the nurse to pause and double-check each medication just before it's given.** Verify the prescription, the dose, and intended patient. NEVER interrupt a nurse in the middle of administering a drug unless you sense a mistake.

• **Understand that virtually every patient is at risk to take a fall.** Look for items in the room that might cause a trip, and bring non-skid socks or slippers for your loved one to wear. Ask the nurses about a cane for your loved one to use. Make sure someone is available to help your loved one to the bathroom and back.

"In my experience, everyone in hospitals is well-intentioned. We just need more eyes and ears on patients, and who could be more patient-centered care partners than families?" Curtiss says. "It's so important for families to be engaged and vigilant and to have their eyes wide open when someone they love is in the hospital." ■

COMING IN FUTURE MONTHS

■ Observation vs. inpatient: which to choose

■ Aligning hospital CM with primary care

■ Discharge planning for hard-to-place patients

■ Making sense of CMS' new initiatives

CNE INSTRUCTIONS

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

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

CNE Questions

1. According to Toni Cesta, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY, how can case management directors ensure that their staff have adequate time to do their jobs other than lowering caseloads?
   A. Create specialty positions, such as discharge specialists or transition managers.
   B. Hire clerks to handle paperwork, telephoning, and other tasks that don't require a license.
   C. Invest in case management software.
   D. All of the above.

2. What is the targeted productivity rate for the case management department at Northwestern-Lake Forest Hospital?
   A. 157%
   B. 100%
   C. 95%-125%
   D. 100% to 125%

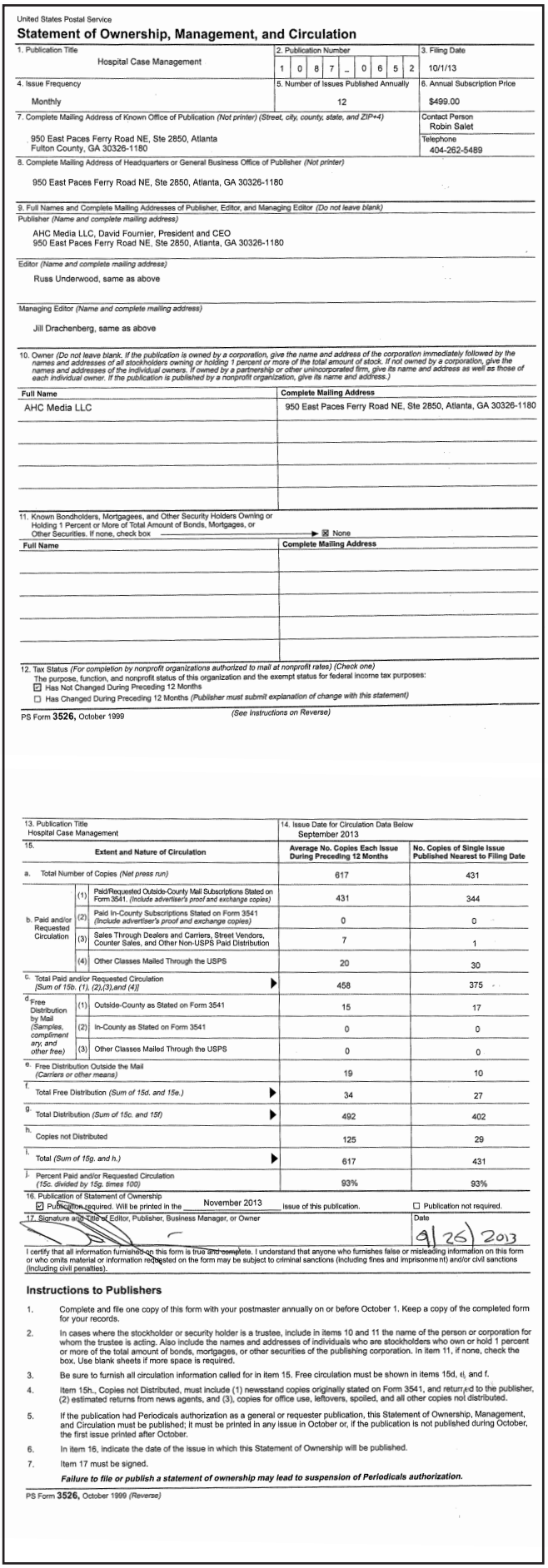
3. How long is the training and orientation program for a typical case manager at Carolinas Healthcare System?
   A. Six weeks
   B. Eight weeks
   C. 12 weeks
   D. One year

4. According to Shreya Kangovi, MD, lead researcher in a Penn Medicine study, low-income people don't typically come into the emergency room for non-emergent conditions. They come in much sicker than other patients and with conditions that could have been prevented.
   A. True
   B. False

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.



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CASE MANAGEMENT INSIDER
Case manager to case manager

Centers for Medicare & Medicaid Services – New Interpretive Guidelines for the Conditions of Participation for Discharge Planning – Part 1

Toni Cesta, PhD, RN, FAAN

Introduction – The Discharge Planning Process

The Conditions of Participation (CoP) for discharge planning were adopted in 1994. This year, 2013, The Centers for Medicare & Medicaid Services (CMS), have updated these guidelines and clarified some of the language. The clarifications are called "interpretive guidelines." CMS is clear to say that hospitals are not bound to the interpretative guidelines and that they are for informational purposes only. As case managers, it is critical that you and your fellow staff members are always up to date and informed concerning the CoP, particularly those components of the CoP most closely related to our roles as case managers. So in addition to the CoP for discharge planning, you should also familiarize yourself with the CoP for utilization review. However, this month we will be focusing on the CoP for discharge planning.

What is Discharge Planning?

Discharge planning is a process. As such, it begins on admission, or before admission, and continues until the patient has safely arrived at the next level of care. It is a process by which a systematic approach is used to facilitate the transition of the patient from one level of care to another as the patient's condition and care needs change.

Medicare defines discharge planning as "a process used to decide what a patient needs for a smooth move from one level to another." *(See www.cms.gov/cfcsandcops/.)*

The process should include the following:

- admission assessment for initial discharge planning purposes;
- planning the stay from door to door;
- collaboratively determining level of care for post-discharge;
- re-assessment daily;
- connecting patient to post-acute services;
- final assessment;
- transitioning patient to the next level of care.

As with other case management processes, we must remember that the process is not always linear. Sometimes steps in the process may need to be repeated as the patient's needs and condition change. This is particularly true for the discharge planning process. In fact, the guidelines clearly state that changes in the patient's condition may warrant a new discharge plan, or a change to the existing discharge plan. For this reason, your hospital must have a policy and procedure that addresses how the discharge planning staff will be made aware of changes in the patient's condition that may warrant a change to the discharge plan. This supports case management best practice, which recommends that every patient be reassessed daily.

Interpretive Guidelines

CMS released an update of Appendix A of the State Operations Manual. This update provided revised interpretive guidelines for the discharge planning CoP at *42 CFR 482.43*, discharge planning. If you are interested in reading the entire document, you can find it at www.cms.gov/cfcsandcops/.

The new interpretive guidelines use language not seen before in the CoP for discharge planning.

Care transitions as a concept is new to the CoP and a welcomed addition. While CMS continues to use the term "discharge planning," it makes note of the fact that the newer language of "transition planning" or "community care transitions" may be preferred by some. This preference, particularly in case management, addresses the idea that patient transitions occur among multiple types of patient care settings that may be included in the care of patients across the continuum.

Interpretive Guidelines for 42 CFR 482.3

"The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing."

CMS is making the distinction in the statement above that all patients must have the discharge planning process applied to them, not just Medicare patients. While this specifically applies to inpatients being discharged from the hospital, CMS comments that similar processes should be developed for ambulatory surgery, observation and similar patients treated at an outpatient level of care.

The interpretive guidelines also make mention of "readmissions" in this section. CMS comments that "when discharge planning is well executed," the patient proceeds toward the goal of his or her plan of care after discharge. In other words, the patient continues to recover outside the hospital, and in the most appropriate setting. CMS acknowledges that some patients may be readmitted within thirty days, and that this may, in some circumstances, be unavoidable. By making this statement, they acknowledge that even under the best of circumstances, some patients will return to the hospital within thirty days.

Concerning Readmissions

The guidelines support and suggest that hospitals be well-advised to assume that every inpatient requires a discharge plan to reduce the risk of adverse health consequences post-discharge. This would include a readmission to the hospital. They go on to say that screening processes may result in some patients being missed for the purposes of discharge planning. Best practice case management models support this approach. Every patient should be assessed by a case manager and should be followed for the purposes of discharge planning, among other things.

It is important to note that not every patient's discharge plan will be a complex plan. Some patients may need nothing more than clear instructions on how to care for themselves at home. If this is the best plan for your patient, then this is what should be documented in the medical record. By documenting this, you are demonstrating that you assessed the patient and his or her plan for discharge was addressed and considered. A note that simply states "no discharge needs identified" is inadequate and does not reflect the case management process.

Screening Patients for Discharge Planning Needs

The interpretive guidelines also explain that, if your hospital does not case manage every patient, then you must have a policy and procedure that documents the criteria and screening process you use to identify patients that are likely to need discharge planning. Since discharge planning is such a fluid process, this will be hard to support in your policies. You will have to include the basis for the screening criteria that you are using, and the actual screening process itself. You must also identify the staff that are responsible for conducting the screening process by title.

The guidelines do not mandate the timeframe for when the identification of the patient's discharge needs should take place. Obviously, from a case management perspective, this should be as soon after admission as possible. The guidelines go on to say that, when the process cannot be conducted early in the stay, it should be completed at least 48 hours prior to discharge when at all possible, assuming that the late assessment did not result in a delay in the discharge process. A delay would be interpreted as a delay in placing the patient in the next appropriate setting, due to a process delay on the part of the hospital.

Survey Procedures

The following are recommended procedures that you can carry out in your department to ensure that you are compliant with the issues we have just reviewed.

- In hospitals that do not require that every patient be given a discharge evaluation (assessment), is there a timely screening to determine if a discharge planning evaluation is needed?

• Was the screening done to

– identify patients needing a discharge planning evaluation?

– Is the hospital in compliance with conducting this greater than 48 hours prior to discharge?

– For patients whose length of stay is less than 48 hours, is there evidence of a screening done?

• Can staff demonstrate that the hospital's criteria for screening is correctly applied?

• If the patient doesn't initially have any identified discharge needs, can you demonstrate that there is a process for updating the patient's condition or circumstances?

• Does your policy have a process for an evaluation of a patient that did not initially have an identified discharge need?

• Are inpatient staff aware of who and how to notify if the patient's condition changes in a way that requires a change to the discharge plan?

482.43(b) Standard: Discharge Planning Evaluation

This standard states

"1. The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.

* * *

"3. The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.

"4. The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital."

Interpretive Guidelines for 482.43(b), 1, 3, and 4

For this standard, every patient that is identified as a potential risk for an adverse outcome, should they not have a discharge plan, must have one completed. Unless your hospital's policy is to evaluate every patient for the purposes of discharge planning, the hospital must provide a discharge plan if the patient, physician, or patient's representative requests one. Patients must be notified that this option is available to them and this should be documented in the medical record. Even if the patient does not meet the screening criteria, you must provide discharge planning if requested.

Interpretive Guidelines for 482.43 (b) (4)

This section requires that the evaluation include an assessment of the patient's capacity for self-care. If this is not possible, then an assessment of how the patient will be cared for by others must be included. CMS suggests that the best discharge goal for patients is to return them to their prior living situation whenever possible.

As we discussed earlier, these guidelines require that a thorough assessment be done on your patients and that this assessment be as comprehensive as possible. In your assessment you should consider what the patient's immediate care needs will be, but you must also project beyond the immediate post-discharge period. In your assessment you should consider whether the patient's current clinical state will remain constant or diminish over time. You must also consider whether the patient's residence can support his or her post-hospital clinical needs. Your assessment must consider whether the patient may need specific durable medical equipment in the home as well as any other special needs the patient may have.

Interpretive Guidelines for 482.43 (b) (3)

This section discusses the likelihood of the patient and family being able to manage their post-discharge needs as well as the availability of those needed services.

As case managers, we must evaluate and provide for any community-based services that the patient may need in order for them to continue living at home.

Such services include

• home health, attendant care;

• hospice or palliative care;

• respiratory care;

• rehabilitation services including physical, speech and occupational therapy;

• end-stage renal dialysis services;

• pharmaceuticals and related supplies;

• nutritional consultation and /or supplemental diets;

• medical equipment and related supplies.

Less traditional services include

• home and physical environment modifications;

• transportation services;

• meal services;

• household services such as housekeeping or shopping.

Each of these potential categories should be included in your assessment form.

Other issues to consider would include a follow-up appointment with the patient's primary care doctor, surgeon or specialist, or a series of appointments for physical or occupational therapy. It is recommended that in your role as a case manager, you facilitate the making of these appointments and not leave them up to the patient alone. Patients may not make the appointments in a timely manner, and this may result in a return to the emergency department or an unnecessary admission to the hospital. For these reasons, case managers must project beyond the immediate discharge while considering the patient's capacity for self-care, including making and keeping appointments.

Our goal as case managers is to always consider the level of care that meets the patients' needs with the goal of keeping the patient at home whenever possible. If this is not possible, then transfer to a facility may be necessary. This transfer may be for a short period of time or may be a permanent placement.

Involving the Patient and Family

As case managers, we are expected to have knowledge of the capabilities and capacities of the long-term care facilities that we refer patients to. In addition, we must discuss the possibility of any out-of-pocket expenses with the patient and/or family. We are required to have a general knowledge of the terms of a patient's insurance, particularly as to how this relates to the availability of post-acute services for the patient. Should the needed post-acute services not be covered by the patient's insurance plan, then this financial liability must be discussed with the patient and family. Should the patient not want to, or be unable to pay out of pocket for the services, then alternative arrangements must be made.

The CoP also provides that the patient has the right to participate in the development and implementation of his or her plan of care. As case managers, we should always include the patient and/or family in the discharge planning process from the beginning of the stay onward. In addition to providing choice in the selection of post-acute services, CMS requires that we incorporate the patient's goals and preferences into the evaluation as much as possible. As case managers, we must develop a relationship with the patient and family from day one of the hospital stay. Discharge planning cannot be conducted from the chart and in the absence of the patient. By working directly with the patient and family, we have a much higher likelihood of developing a successful discharge plan that will result in a successful outcome.

Interpretive Guidelines for 482.43 (b)(2)

This section states that a registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise, the development of the evaluation.

Your department's policies and procedures should specify the qualifications needed to be a discharge planner in your hospital. Qualifications should include the following:

• previous experience in discharge planning or training in discharge planning;

• knowledge of clinical and social factors that affect the patient's functional status at discharge;

• knowledge of community resources to meet post-discharge clinical and social needs;

• assessment skills;

• insurance/financial factors to be considered in development of a discharge plan;

• physical factors to be considered in development of a discharge plan.

Interpretive Guidelines for 484.43 (b)(5)

This section states that hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

While CMS does not stipulate the exact time frame for completing the initial discharge planning assessment, it does indicate that it should be done in a time frame that allows completion of arrangements without delay in the patient's inpatient stay. Because the national average length of stay is fairly short, this means that the process should begin as soon after admission as possible. The process should be collaborative, including the entire interdisciplinary care team. As discussed earlier, reassessment should occur daily so that changes in the patient's clinical condition can be taken into account while developing the discharge plan.

Next month we will continue reviewing the interpretative guidelines for the CoP for discharge planning. ■