HOSPITAL CASE MANAGEMENT™

the monthly update on hospital-based care planning and critical paths

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Assign cases based on acuity level of patients, not just on the number

Managing some cases takes a few minutes; others take hours

If one case manager oversees the care of 20 patients in a day and another handles only 18 cases, the first case manager must be more productive, right?

Not necessarily, asserts **Teresa C. Fugate**, RN, BBA, CPHQ, CCM, manager of Pershing, Yoakley & Associates, a Knoxville, TN-based health care consulting firm.

"It's not comparing apples to apples. One individual patient could take 15 minutes, and another could take two hours, depending on the number of functions the case manager may perform with a given patient," she says.

In some cases, 20 patients could take only five hours in a day, while 18 patients could take 16 hours, she adds.

That's why Fugate advocates a system in which case managers are assigned cases based on how long each is expected to take, rather than just dividing up the number of cases on a particular unit.

She recommends that hospital case management departments define the activities required by case managers and perform time studies to determine the estimated time it takes to handle various case management activities. Once the manager has a good idea of the time involved in handling each activity, he or she can base assignments on the expected length of time for each case. **(For details on how an acuity-based system works, see related article, p. 83.)**

Switching to an acuity-based system for case management assignments can result in big benefits for your case management department, Fugate says.

Not only will it help spread out the workload evenly, it is a good way to measure the productivity of your staff and justify to management the need to increase or reduce staffing, she adds.

For example, one hospital case management department was able to

show the need for three new case manager positions at a time when other departments were being asked to cut staff.

"First, they were able to show the benefit of case management, how they were reducing the denials and making sure the hospital was compliant with regulations," Fugate says. "However, there was only so much time in the day to perform the required functions, and areas of risk were being overlooked. Using an acuity-based system, the manager was able to justify the need for three new staff."

By compiling the amount of time case managers were spending doing clerical jobs, such as faxing and sending out letters, the case management department saw the benefit in hiring two clerical people instead of filling one of the case management positions it had open, redesigning the activities, and freeing up the case managers to work with patients.

"Copying or faxing is a clerical activity, not a professional activity. It's ridiculous to pay professionals to do nonprofessional jobs," she adds.

At another facility, data collected helped the administration realize how much time case managers were spending on hold during phone calls to provide clinical information to commercial payers. By redesigning the process and activities performed, the department set it up so a clerical person who does data entry can hold for the case manager. Case managers carry walkie-talkies and are notified when the call comes in.

"The case managers are able to utilize their time more efficiently to intervene with physicians or perform quality reviews instead of tying up a line on the nursing unit and having their time wasted on hold," she says.

Haywood Regional Medical Center in Clyde, NC, has been using an acuity-based system for case assignments for more than five years and is pleased with the results, says **Shirley Trantham**, RN, BSN, CCM, director of health resource services in the case management department at the 200-bed hospital.

The hospital has seven case managers, one of whom spends half her time on infection control activities. Two social workers handle placements and psychosocial problems and fill in when the case managers are overloaded.

Trantham initially started measuring acuity as a way of showing the need for more case managers in her department. Her case management staff has increased by 2.5 full-time equivalent positions since she started measuring acuity.

How the system works

Here's how Haywood's acuity system works:

The case management department receives a worksheet each morning for new patients admitted in the past 24 hours. The case manager who handles the particular unit to which each patient is assigned reviews the worksheet and uses a guide to determine approximately how much time he or she can expect to spend with the patient.

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Editorial Questions

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"We know if the patient has a high-risk diagnosis or if the patient is on a pathway, it will take longer than other patients. The case managers do education for the high-risk patients, discharge planning, quality review, utilization review, and utilization management. They take all of that into consideration," Trantham says.

The case managers write the amount of time they expect to spend on each patient on a board in the case management department and enter it into a log book.

Trantham looks at who has the biggest caseload and determines if she should switch patients from one case manager to another or if she needs to assist in taking care of the patients.

The information on the board does not contain patient names, only the case manager's name, the unit, and the number of hours.

The honor system works extremely well, she says. "The staff are more likely to assign too little acuity to the patients rather than too much time. Somehow, it all works out. They may overshoot on one patient, but something they didn't anticipate on another case adds an extra hour."

By lunch, Trantham and her staff have a good idea whether the work is going as planned and can make adjustments.

The case managers also note their nonpatient hours, such as going to meetings.

Trantham periodically goes through the information in the log book to come up with productivity measures for the department and each case manager.

The flaw in assigning patients by census is that it doesn't account for the amount of time involved in a particular patient's case, Fugate says.

A case manager who is struggling to take care of the needs of several complicated patients during the day may not have time to do chart reviews of her other patients and may miss physician orders, such as an order to discharge the patient if a chest X-ray is clear. In that case, a patient may remain in the hospital for another day and may no longer meet the insurer's medical necessity criteria, resulting in a denial of authorization for the continued stay.

Assigning case managers on an acuity basis can't take care of every problem that is likely to arise, but it can help, Fugate says.

Census-based assignments usually do not allow for adequate cross-coverage for staff and offer no accountability for case managers to assist overburdened colleagues.

If a case manager finishes the cases she is assigned, under a census-based system, she may go home instead of assisting those who have complicated cases or, if she does offer assistance, the offer may be too late to prevent a delay in service, Fugate says.

"Under a census-based system, what people don't realize is that they may be short of staff, but there's no way to prove it because there is no way to measure true productivity," she adds. ■

Time studies facilitate case assignment

Average out the times for each task

A time study is one way to measure productivity at the same time you reduce the disparity in assignments between your case managers.

"Case managers know instinctively about how much time it's going to take to manage some patients. That's why they get so stressed out when they think there is no way they can get everything done in one day. A time study that shows how much time each task may take is a way to show that they may be right — they can't do it all in one day," says **Teresa C. Fugate**, RN, BBA, CPHQ, CCM, manager for Pershing, Yoakley & Associates, a Knoxville, TN-based health care consulting firm.

Making a list of case managers' activities

Start your time study by listing each activity that case managers perform.

Assign each case manager the job of keeping track of all the activities they perform each day for each patient and the time involved for each activity during a certain time span. **(For a look at some of the activities you should consider, see list, p. 84.)**

To avoid frustrating your already busy staff, Fugate recommends performing the time study one day a week for five weeks so every day of the week is covered, and average the time. Using historical data, come up with the numbers and types of diagnoses you can expect to have.

Assign a time-based system for each activity. For instance, a new review may take an average of 20 to 25 minutes. A continuing stay review looking at just one episode may take only 10 minutes.

"Once you do the time study, there are indications based on patient demographics that will give you an idea of the possibility of acuity level," Fugate says.

The person who makes the assignments each morning should look at the demographics and determine the acuity level for each patient based on the time studies.

"A calculated task may take 30 to 40 minutes for one patient and only 10 to 15 with another, depending on their acuity level and the activities that are likely to happen with the patient," says Fugate.

For instance, if a patient has commercial insurance, the person who makes the assignments knows the case manager will have to make an insurance call.

The assigner generally can tell how in-depth a psychosocial assessment will be by the age and diagnosis of the patient. He or she knows which core measures on the care path are being monitored for the Joint Commission on Accreditation of Healthcare Organizations and how much time that will take.

"They know, based on demographic information, the sort of time each individual patient will take. This way, the patients can be divvied out based on the amount of time it is estimated will be involved in taking care of the patient that day," she adds.

For instance, if a patient is 70 years old with a history of congestive heart failure and previous readmissions within the last few months, this is a red flag that this patient is likely to consume a lot of a case manager's time.

Based on time studies, you may know that the chart review for a new patient will take 20 minutes, a full assessment will take 20 minutes, and an assessment of the psychosocial issues is likely to take 20 minutes. If it's a Medicare patient, the case manager won't have to make an insurance call, but he or she may have to set up durable medical equipment.

At lunchtime, the supervisor should look to see whether the time it is taking for each patient is running close to the anticipated time. He or she can make adjustments and reassign patients if necessary.

"The system is time-driven," Fugate says.

At the end of the day, the case managers can anticipate what they have to do tomorrow and

List case management-related tasks before time studies

Activities depend on hospital's model

A hospital case management model may include utilization management, discharge planning, quality improvement, risk management, or clinical care management, all under one umbrella.

"Case managers don't do all these functions in all hospitals. There may be a social worker who handles discharge planning and a case manager looking at the clinical aspects, or they may be integrated so case managers do all of that work," says **Teresa C. Fugate**, RN, BBA, CPHQ, CCM, manager, Pershing, Yoakley & Associates, a Knoxville, TN-based health care consulting firm.

Before you do the time studies involved in setting up an acuity-based case management assignment system, you should define the activities involved in case management at your specific organization.

Include a column for clerical activities and other nonprofessional tasks they are expected to undertake. Here are some questions to ask:

- ✔ Do case managers perform utilization management?
- ✔ Are they assessing delays in services or intervening to prevent delays in services?
- ✔ Is it their responsibility to check orders and call the physicians with results of tests?
- ✔ Do they monitor medical necessity and intervene with the physicians to say that the situation no longer meets the lower level of care requirements?
- ✔ Do they work with physicians to assist in documentation to meet compliance requirements?
- ✔ Does their job include discharge planning?
- ✔ Do the case management activities extend to setting up transportation, arranging for home health and durable medical equipment, and making the patient's next appointment with a physician?
- ✔ Are the case managers monitoring protocols?
- ✔ Do case managers collect information for the Joint Commission on Accreditation of Healthcare Organizations core measures?
- ✔ Are case managers responsible to see that there is compliance on risk-related issues, such as alerting someone to risk-related pain management? ■

how much time it can take. They can enter that information on a simple data entry system that the person making the assignments the next day can use.

For instance, a case manager may say she has six patients remaining that can be expected to take a total of two hours time.

The supervisor who makes the assignments the next day looks at how many hours the case managers will work and how much time the patients left over from the day before will take, and bases the assignments on that.

An acuity system allows supervisors to enter anticipated time, then enter the actual time it took and compare the two.

"They can adjust their time-study data and do more training to help people better anticipate the time it takes to manage the care of each patient," she says.

As a bonus, if case managers are paid by the hour, the supervisors can look at the time studies as a way to reduce overtime pay.

The time studies give case management supervisors a chance to look at any type of nonprofessional activities, such as sending out letters, making copies, and waiting on hold on the telephone. These data can be used to justify hiring clerical workers, Fugate says. ■

Electronic system places patients in post-acute care

Cuts length of stay, saves time for case managers

Discharge planning for patients who need long-term care often is a challenge for hospital case managers, particularly if the patient is from another region.

They are faced with finding care for a complex patient in another state where they are likely to have limited knowledge of referring facilities.

As a result, the discharge planning process can involve a lot of research and literally hours of faxing documents and calling back and forth, often delaying discharge from the acute care hospital.

Case management departments in two hospitals that frequently treat seriously injured vacationers and other patients residing in a wide geographical area are among those who have found a solution to their discharge planning needs by contracting with an electronic discharge planning system that provides secure, Health Insurance Portability and Accountability Act (HIPAA)-compliant communication via the Internet with post-acute facilities all over the country.

"It's all part of our vision to improve patient flow, to know our outcomes, and to have the resources to get the patients to the right location at the right time," says **Lynne S. Nemeth**, RN, MS, director of care management, research, and evaluation, at the Medical University of South Carolina (MUSC) in Charleston.

Making a complex process a lot easier

In one example, using an electronic discharge planning system turned what once would have been a long, tedious process of finding care for a complex patient in another state into an easy process, says **Kim Egbert**, RN, MSN, a care manager at MUSC.

The patient, a resident of New York state, traveling in South Carolina, was in a motor vehicle accident that left him a ventilator-dependent quadriplegic with no funding for long-term care. The family wanted him discharged to a facility near their home.

Egbert sent out more than 80 referrals in a matter of a few minutes and over the next few days received replies from several facilities that were not just willing but eager to admit the patient.

"I was able to place him with no difficulty at all," Egbert says.

In the first six months that Sentara Virginia Beach (VA) General Hospital used an electronic discharge planning system, *e*Dicharge from Newton, MA-based CuraSpan, the case managers were able to decrease the length of stay for patients transferred to skilled nursing facilities by 0.3 days.

"Over time, we expect to see the overall length of stay decrease. Now with the capability of placing skilled nursing facilities patients more efficiently by *e*Dicharge, the case managers have the time to work on the complex cases," says **Julie M. Miller**, RN, BSN, manager of continuing care at the hospital.

Time savings are harder to quantify, Miller says, adding the case managers report that it is much less time-consuming to complete placements.

"We were spending a lot of time faxing multiple documents and making multiple phone calls back and forth to long-term care facilities, rehabilitation facilities, and skilled nursing facilities,"

says **Dee Paske,** RN, CCM, nurse case manager at Sentara Virginia Beach. Finding post-acute care for an out-of-state patient usually means calling the family physician, asking for suggestions, and doing a lot of research before locating a facility, she says.

Both hospitals have a contract with CuraSpan, a provider of connectivity and network management, for its *e*Dicharge platform discharge planning solution.

The system allows the case manager to enter the city, state, and zip code into the *e*Discharge database to find available facilities and resources where the patient chooses to receive care.

The hospital case managers use an electronic version of a state-mandated or other screening form, including the NASPAC form, developed by the National Association of Subacute and Post Acute Care, in addition to providing demographic, financial, and diagnosis information.

Case management staff can simultaneously send out 10, 15, or even more inquiries with an electronic discharge planning system when they might have sent out two or three if they had to fax the information to one facility at a time.

A facility using the *e*Discharge system uses it for all referrals, whether they are local or out of region. The electronic discharge system has been of the greatest benefit when it comes to finding post-acute care for difficult-to-place patients, Miller adds.

"Ventilator beds and isolation beds are hard to come by. By getting our patients into the system as early as possible, we can get them approved and on the facility waiting lists," Miller says.

The system allows supervisors to track referral patterns, such as how many referrals are sent to a certain facility and how many were accepted, Nemeth adds.

"Overall, it's a better way to evaluate the business outcomes. As a director, I can evaluate the outcomes and interventions of my team," she says.

"When we have a full house and the administration asks what we are doing to open up beds, I can show them how many referrals went out and what we are doing to manage patient flow," Nemeth explains.

(Editor's note: The Centers for Medicare & Medicaid has set up a Nursing Home Compare site, which provides detailed information about the past performance of every Medicare- and Medicaid-certified nursing home in the country, listed by geographical area. Go to: www.medicare.gov/NHCompare/home.asp.) ■

Electronic system takes time and patience

Ensure staff, referral sources understand system

Switching to an electronic discharge system was a culture shift, not only for Charleston-based Medical University of South Carolina (MUSC) staff but for local providers as well.

"It was confusing to the local facilities that the Medical University of South Carolina was sending out placement inquiries through an outside provider," says **Lynne S. Nemeth**, RN, MS, director of care management, research, and evaluation at MUSC.

Nemeth made appointments with the directors and administrative coordinators of local post-acute care providers, told them about the *e*Discharge system, and introduced them to her vision.

"Our vision was to reduce length of stay, to reduce the time it takes the staff to make a referral, and to improve the facilities' ability to make a decision about acceptance based on the information we provide," she says.

The hospital held information sessions for local providers before they went live.

"It was a little bit of a push to get them to consider it. They had to become *e*Discharge members to communicate electronically. The smaller facilities had concerns about paying more money to get our business. It took a little time working with them," Nemeth says.

Often, the receiving facilities feel like they need to see the patient. "We assured them that we were providing them with the assessment of a masters'-prepared nurse care manager or social worker who would present the patient's needs accurately and objectively using the NASPAC assessment form, [developed by the National Association of Subacute and Post Acute Care]. We wanted to improve our ability to communicate with them and to develop a sense of trust," Nemeth adds.

The hardest part about the transition is the elimination of personal relationships between the staff and the people at the facilities to which they refer patients, Nemeth says.

"The staff were working on relationships. Now they're working on facts. In a way, I view that as positive. It's great to have good relationships, but it

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AMBULATORY CARE
QUARTERLY

Speed up orders for inpatients held in ED

What is your No. 1 obstacle to reducing delays and improving patient flow? For many emergency department (ED) managers, the culprit increasingly is inpatients being held in the ED for hours or even days.

"If we can expedite getting the patients out of the ED, of course that is best," says **Jay Kaplan**, MD, FACEP, medical director of the Studer Group, a Gulf Breeze, FL-based group that specializes in operational and service improvement in EDs and health care facilities.

"If we can't, it is vital to recognize what orders need to be carried out immediately and which can wait until the patient gets to the floor," Kaplan says. "The problem, of course, is that too often you don't have any idea how long the patient is going to be held in the ED."

Here are strategies to manage orders for inpatients held in the ED:

- **Determine which orders need to be carried out immediately.**

You need a foolproof system to ensure that important orders are carried out while the patient is in the ED, Kaplan says. "The problem is that often this system is not set up, and thus there may be a delay in important orders being carried out," he says.

Often, inpatient order sheets are used, which fail to differentiate which orders must be done in the ED and which ones can wait, Kaplan notes. "Given the uncertainty as to how long the patient will be in the ED, there is confusion, and it must not be left up to an individual's discretion as to which orders are carried out.

"It is equally unreasonable to expect ED nurses, with all of their other patient responsibilities, to do everything. This is problematic," he adds.

Use a protocol for inpatient orders to ensure that important orders are carried out while the patient still is in the ED, he recommends.

- **Resist pressure for ED physicians to write inpatient orders.**

The Dallas-based American College of Emergency Physicians has taken a position against ED physicians writing inpatient orders, Kaplan says. "In that scenario, once the patient leaves the ED, the emergency physician is taking responsibility for the patient on the inpatient unit and before the attending physician has taken charge of the care," he explains.

"This is an untenable situation. You can't have two captains steering the same ship." However, there often is pressure put on ED physicians to write these orders so that private attendings do not have to see patients, Kaplan says.

Create a template that includes the statement "Call Dr. _____ upon patient arrival to unit for orders," he advises.

There also should be a clear statement that once a private physician has called in orders on a patient, or house staff have come down and written orders on behalf of an attending physician, the ED physician no longer is responsible for the patient unless there is a life-threatening emergency, he says.

- **Use transitional orders.**

At Englewood (NJ) Hospital and Medical Center, patients being held in the ED encountered a Catch-22 scenario: Inpatient units would not accept patients without orders, and the ED physicians did not want to write admitting orders because of the liability risks involved, reports **Stuart M. Caplen**, MD, chief of the department of emergency medicine.

As a result, patients would wait in the ED until the residents worked them up, he explains.

Caplen's ED found an effective solution by working with the departments of medicine and nursing to develop "transitional" orders to use for inpatients being held in the ED. The orders provide for activity, diet, and first dose of pain medication or other stat medications.

The patient's attending physician and the resident are called and notified that the patient will

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Admitted Patient Transitional Order Sheet

Medical Resident Covered Patients

ALLERGIES: _____

_____

Date & Time	**Other Orders**	**Prescription and Infusion Orders**
	Diagnosis: _____	IV Order: _____
	Activity: _____	_____
	Diet: _____	_____
	Other Orders: _____	_____
	Call medical resident on call (beeper 1700) when patient arrives on floor to examine patient and for further orders	Pain Medication: First Dose Only: _____
	<u>For Telemetry Patients</u>	
	1. Notify medical resident on call or code team immediately for any life-threatening dysrhythmia, change in condition, or performance of any of the following orders:	_____
	2. Stat defibrillation of V. Fib or pulseless v. tach., as per ACLS guidelines.	_____
	3. Cardiovert v. tach. If unstable and unconscious as per ACLS guidelines.	_____
	4. For sustained v. tach. of 30 seconds or more: Lidocaine 1 mg/kg over 2 min and then: Lidocaine 2 GM in D5W 250 ml IV at 2 mg/min.	_____
	5. For symptomatic bradycardia: Attach pacemaker pads and start pacemaker at 30 MA setting with rate of 50 beats per minute. Increase MA setting upward until capture is attained. Have atropine 0.5 mg at bedside. If pacemaker unable to capture or pacemaker is not immediately available, give 0.5 mg atropine IV push.	_____
	6. For angina: Stat EKG then nitroglycerin gr 1/150 SL stat if not hypotensive.	_____
	7. Supplemental oxygen should be given for all the above conditions, to maintain oxygen saturation between 95% and 100%. If patient has COPD, maintain oxygen saturation between 90% and 95%.	_____
	Signature: _____	

Source: Englewood (NJ) Hospital and Medical Center.

be sent to the floor for the admitting history, physical, and orders. A preprinted sheet is used and one of the first orders is to page the resident when the patient arrives on the floor. **(See Admitted Patient Transitional Order Sheet, p. 92.)**

Transitional orders are used only for relatively stable patients, such as patients with infections who have gotten their first doses of antibiotics in the ED, who can safely wait one or two hours for the resident to see them on the inpatient floor, Caplen notes.

When transitional orders were first implemented, the ED agreed to wait one hour to notify the resident before using the orders to give the resident time if he or she wanted to see the patient in the ED. The one-hour waiting period has been eliminated to speed the process when the ED is busy, he says. The transitional orders have gotten patients up to the floor several hours quicker, by not having to wait for the resident to examine the patient in the ED and write admitting orders, Caplen reports.

A recent example involved an elderly patient with pneumonia who was not in acute respiratory distress, he says. The woman received the first dose of antibiotics in the ED and later went to the inpatient floor, where the resident examined the patient and did the history and physical.

"An additional bed for new ED patients opened up several hours earlier than it would have, had the transitional orders not been used," Caplen says.

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Use protocol to send inpatient holds upstairs

It was a typical scenario: The emergency department (ED) at Stonybrook (NY) University Medical Center was holding 15 or 20 admitted patients waiting for an inpatient bed to become available. This was a common occurrence, but **Peter Viccellio**, MD, FACEP, vice chairman of the department of emergency medicine for the school of medicine at State University of New York at Stony Brook, was fed up. "We had a longstanding history with the New York state health department, so I called a senior person," Viccellio says. "I asked in frustration why it's against health codes to hold patients upstairs in hallways, but it's OK for us to hold them in the ED," he says.

Viccellio was surprised to learn that no such distinction is made. "It's a myth that has been perpetuated in hospitals for many years, but there is no specific code against holding patients upstairs," he says. Viccellio asked the official to put this in writing. "They wrote a series of letters saying that holding patients upstairs is encouraged and that boarding of inpatients in the ED is unacceptable," he says. (The letters can be viewed at www.viccellio.com/overcrowding.htm. Click on "Page 1," and "Page 2.")

As a result, Viccellio began lobbying to have admitted patients being held in the ED instead sent upstairs. "It became clear that this was obviously in the patient's best interest," he says.

"Patients deserve the expertise of the inpatient physician and inpatient nurse." A "full-capacity protocol" was developed that requires patients to be held upstairs, often in the hallway, when the ED is at full capacity. "When we have to see newly arriving patients in our hallway, it is time for patients to be moved upstairs," says Viccellio.

The practice of holding inpatients in the ED came about as a result of lack of clout for EDs in general, he says.

"This practice went on for so long that a new generation of physicians, nurses, and administrators believe that this is the way things are supposed to happen. It makes absolutely no sense whatsoever. It never did and never will." Building a unit adjacent to the ED for overflow admissions is not a real solution, says Viccellio. "You still have the same problem, because there is no inpatient physician and nurse," he explains.

Here are benefits of the full-capacity protocol:

• **Patients are given better care.** ED patients are seen more quickly as a result of the protocol, Viccellio says. "Our driving concern was giving people appropriate medical care," he says. "To force critically ill people to stay in the waiting room for hours so that the hospital can store all the admitted patients in the ED doesn't make sense." However, the ED still holds inpatients for specialty units such as critical care and respiratory

patients, he notes. "The problem that continues to plague us is that the protocol only applies to people we would put in our own hallways. Other patients still remain in the ED because there is no bed for them upstairs. But even given that limitation, the ability to move patients upstairs has a profound affect on diminishing the time patients wait for a doctor."

The full capacity protocol puts the focus on what is best for the patient, as opposed to the competing interests of individual departments, says **Carolyn Santora**, RN, MS, the facility's associate director of critical care nursing.

Admitted patients are better served being held on the unit where inpatient nurses can provide appropriate care, says **Cheryl A. Barraco**, RN, MS, nurse manager of the ED. "For example, if cardiac patients are being held in the hallway on the floor instead of the ED, even though they are not in a room, they are still being cared for by inpatient nurses," she says.

• **Beds may become available immediately.** There are times that departments are overloaded, and there aren't any beds, Viccellio adds. "But oftentimes, when patients are moved upstairs to the hallway, a bed magically becomes available." This behavior is rampant throughout the hospital industry, he says.

"The bed may become available at 1 o'clock, but it doesn't get reported until the change of shift," he says. Trying to get patients discharged early and nurses to report an available bed is fighting a losing battle, says Viccellio. "There is no incentive for them to rush or get patients upstairs. Once the problem is put in their lap, then they act to solve that problem."

• **Length of stay is reduced.** The facility did a study which found that the average length of stay for admitted patients held in the ED was 6.2 days, as compared with 5.4 days for the patients moved upstairs, Viccellio reports. "Most hospital administrators would love to get that much of a reduction in length of stay," he says.

• **Morale of ED nursing staff improves.** The full capacity protocol improved morale because ED nurses are freed to care for their own patients, says Barraco. "We aren't dividing our time between taking care of admitted and ED patients, so we can concentrate on our specialty, which is the care of ED patients," she says.

[For more information, contact:

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CE *questions*

This concludes this CE semester, please return the enclosed CE survey form.

23. According to Teresa C. Fugate, switching to an acuity-based system for case management assignments can have which of the following benefits?
    A. It can help measure the productivity of staff.
    B. It can help spread out the workload evenly.
    C. It can help justify to management the need to increase or reduce staffing.
    D. all of the above

24. Since she started measuring acuity, Shirley Trantham's case management staff at Haywood Regional Medical Center in Clyde, NC, have increased by how much?
    A. 1 FTE
    B. 2.5 FTEs
    C. 3 FTEs
    D. 4.5 FTEs

25. In the first six months that Sentara Virginia Beach General Hospital used an electronic discharge planning system, the case managers there were able to decrease the length of stay for patients transferred to skilled nursing facilities by how many days?
    A. 0 days
    B. 0.3 days
    C. 0.8 days
    D. 1.5 days

26. When did the first Certified Case Manager examination take place?
    A. July 1998
    B. January 1995
    C. May 1993
    D. April 1992

Answer Key: 23. D; 24. B; 25. B; 26. C

(Continued from page 86)

doesn't ensure that everyone has an equal chance," she says.

The staff at Sentara Virginia Beach generally were enthusiastic about the program, says **Julie M. Miller**, RN, BSN, manager of continuing care.

"I was more fearful than I needed to have been about the case management staff using it. The learning curve was steep, but it has been truly embraced. All those back-and-forth phone calls and multiple faxes led to frustration," Miller says.

She suggests that other facilities develop champions for the new system who can support its implementation with the case management and social work staff.

"If a few staff members are enthusiastic about the system, it flows through to the rest of the department," Miller says.

She has some additional advice on setting up an electronic discharge system:

- Involve your information technology people to make sure that you have the equipment and speed you need to handle the transmission of data.
- Make sure your infrastructure is ready and that the interfaces you choose will work appropriately before going live.
- When you are setting up the system, make sure you carefully think through and request the interfaces you need.

After using the electronic discharge system for nine months, Miller says she should have explored an interface with the hospital's demographic and financial information system more thoroughly. ■

CM services may become more important than ever

Services will increase in importance

As the Commission on Certification of Case Managers (CCMC) celebrates its 10th anniversary, leaders in the case management field say the demand for case management will continue to grow as the health care system becomes more chaotic and complicated than ever.

The first Certified Case Manager (CCM) examination took place in May 1993, after more than two years of work by a group of professionals representing case management in a variety of disciplines, practice settings, and geographic locations.

"There is an increased need, not just because of the convolutions in the health care system but because there will be more people who are not well served. They will require someone who is not a hands-on provider to guide them through the process and act as their advocate," says **Catherine Mullahy**, RN, BS, CRRN, CCM, of Options Unlimited in Huntington, NY, and a member of the original task force that developed the credential.

Case managers are going to be dealing with an aging and more seriously ill population as the baby boomers grow older and people with catastrophic illnesses or injuries and people with complex care needs survive longer.

In addition, as the United States becomes more diverse, the number of people with cultural and language barriers can be expected to increase. These people will need an advocate to help them through the system. With increasing health care costs and more people who need complex care, case managers will be under pressure to move patients through the continuum quickly and ensure that they get the care they need.

"We have an opportunity to help resolve the problems that exist in health care delivery by putting a well-educated, experienced care manager in the center with the patient. We've talked for many years about moving patients into the community quicker and sicker. It has never been more so than today," says **Patricia McCollom**, RN, MS, CRRN, CMDM, CCM, CLCP, president of Management Consulting and Rehabilitation Service Inc. in Ankeny, IA.

COMING IN FUTURE MONTHS

- Skills and tools for the effective case manager
- Fostering nurse case manager and social worker collaboration
- Dealing with frequent-flyer patients
- Clinical pathways for COPD and CHF

McCollom chaired the original steering committee of the National Task Force on Case Management, which concluded that the certification of case managers was necessary. She is past chair of CCMC.

When leaders in the case management field were working on establishing the CCM credential, most case managers were either independent or in the insurance world, recalls **Mindy Owen**, RN, CRN, CCM, chair of ethics committee and a member of the CCMC executive board.

Fastest growing segment

Now, facility-based case managers are the fastest growing segment of the profession, she says.

Just 10 years ago, disease management and population-based management were practically unheard of, but they're now a part of case management, Owen adds.

Owen believes that case management credentials eventually will have to include an additional credential representing the setting in which the case manager works, such as a hospital setting, workers' compensation setting, or managed care setting, or a specialty credential such as an oncology case manager or a pediatric case manager.

The nursing shortage means hospital staff have less time for the patient education and patient monitoring that is necessary for good outcomes, making it more important than ever for a case manager to act as patient advocates.

Experienced case managers may be in short supply as those who began when case management was in its infancy retire, McCollom adds.

Educating the public about what case managers do is another challenge since a very small percentage of people has ever been involved with case management and most have no idea what "case management" means.

"Case management tends to be a buzzword, a title that everybody wants to have. The job descriptions inside case management have become so varied that they don't always reflect case management or the function and skill sets needed for case management," Owen points out.

Having the CCM credential can help end some of the confusion, she adds.

"The certification ensures that the individual has a basic knowledge of case management and practices with the understanding of the standards of practice and the code of conduct," Owen explains. ■

CE objectives

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

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■

CRITICAL PATH NETWORK™

Safety concerns should not end with discharge

Preventing errors after patients return home

The transition from hospital to home is a potentially vulnerable period, and the medical community should explore ways to reduce adverse events during this transition, say the authors of a new study in the *Annals of Internal Medicine.*

The study looked at 400 consecutive patients discharged home from an urban teaching hospital in Canada. Researchers focused on adverse outcomes, which they defined as "either new or worsening symptoms, unanticipated visits to health care facilities for tests or treatment, or death."[1]

The study found that 76 patients had adverse events after discharge, which were defined by the authors as "an injury resulting from medical management rather than the underlying disease."[1] The researchers included adverse events that happened in the hospital as well as after discharge, as long as the symptoms persisted until the patient went home. These adverse events were broken down further as follows:

- **Preventable adverse events (23):** Injuries that could have been avoided — judged to be the probable result of an error or a system design flaw.
- **Ameliorable adverse events (24):** Injuries whose severity could have been substantially reduced if different actions or procedures had been performed or followed.

"A preventable adverse event might involve a patient discharged on supplements with no monitoring of electrolytes," explains **Alan J. Forster**, MD, FRCPC, MSc, of the University of Ottawa and lead author of the study. An ameliorable adverse event, he suggests, might involve sending home a patient on certain meds who experienced wheezing that persisted longer than normal, but who received inadequate monitoring.

Adverse drug events were the most common type of adverse event (66%), followed by procedure-related injuries (17%).

Under-recognized problem

The study was undertaken, the authors write, because they suspected that adverse events after discharge was an underappreciated (and understudied) problem.

Referring specifically to the Institute of Medicine report, *To Err is Human*, the researchers noted that it "may underestimate the overall safety problem, since injuries occurring after discharge were not included in the evaluation. Patients may be especially vulnerable to injuries during this period because they still may have functional impairments and because discontinuities may occur at the interface of acute and ambulatory care."[1] They went on to point out, however, that few studies were available to estimate the extent of the problem.

"We speculated in our introduction that the problem could mainly be due to poor organization of care," Forster adds. "But we did not want to blame a group of people or any one specialty. The fact that multiple physicians look after patients over time and in different places clearly makes communication of the care plan difficult, as well as the identification of responsibilities. In fact, it often makes patients quite confused over who makes which decisions," he says.

This did not prevent the authors from concluding, however, that many of the noted adverse events "could potentially have been prevented or ameliorated with simple strategies."[1] They didn't stop with that observation, however. "For the preventable and ameliorable adverse events, we

asked our researchers to identify ways they could be prevented and/or ameliorated," Forster notes.

Here are some of the general themes common to their recommendations:

- **Identify unresolved issues at the time the patient leaves the hospital.**

It's important to conduct a very thorough assessment to determine what issues remain unresolved and need to be monitored, Forster says. "It may not be necessary for the patient to remain hospitalized, but there may still be questions that remain unanswered, so the patient should be monitored closely."

- **Patients must learn more about their meds.**

Patients must know their meds, their potential side effects, and what to do when problems arise. This education should take place before they leave the hospital. "Quite often, patients are in the hospital for a short time, but meds can change quite a lot," Forster says.

"When they leave, even though you may have spent some time teaching them about their meds, they often forget," he adds. "There should be some system in place to make sure they have learned about their meds, and that they have access to help when they come across problems."

- **Improve recognition of drug monitoring responsibility.**

It must be very clear just who is responsible for the monitoring of the drugs, says Forster. "If a patient is sent home on an anticoagulant, who is responsible?" he poses. "Quite often, the hospital physician might assume it's the primary care doc, and vice versa."

Putting a system in place

In general, facilities need to have a better system for identifying general problems and for dealing with common questions and concerns, Forster says.

"There has to be an easy mechanism of communicating back to the hospital; maybe one phone number to call," he offers. "Maybe a callback from the ward, the nurse, or even the pharmacy might be useful."

Reference

1. Forster AJ, Murff HJ, Peterson JF, et al. The incidence and severity of adverse events affecting patients after discharge from the hospital. *Ann Intern Med* 2003; 138:161-167. ■

Baptist Health Care's performance standards

'Be truthful and honest in all dealings'

At Baptist Health Care Corp. in Pensacola, FL, the following question is posed to employees: If I'm going to be successful in this culture, how do I need to act?

Performance standards, compiled by employees, are behaviors to be demonstrated by all employees. The standards establish specific expectations that employees are required to practice diligently while on duty. Picking up trash, walking visitors to their destinations, and a courteous smile to all are just a few examples of how employees can meet the expectations set by their co-workers. The following is an excerpt of some of Baptist Health Care Corp.'s standards:

- **Attitude:** Our job is to serve our customers, co-workers, and supervisors and to provide high-quality service with care and courtesy. Always thank the customers for choosing us. Exceed expectations.
- **Appearance:** Be clean and professional. Follow dress code policies and wear your identification badge correctly at all times. Pick up litter and dispose of it properly. Clean up spills and return equipment to its proper place.
- **Call lights:** All employees are responsible for answering call lights. Acknowledge call lights by the fifth ring, and respond to requests within three minutes. Always address the patient by name. Anticipate patients' needs so they will not have to use their call lights. Ensure continuity of care by reporting to relief caregivers before leaving the floor. Return promptly from breaks. Check on patients one hour before shift change to minimize requests during report.
- **Communication:** Listen to customers, co-workers, and supervisors. Be courteous. Don't use jargon. Keep patient information confidential. When someone appears to need directions, escort him or her to the destination. Know how to operate the telephones in your area. Provide the correct number before transferring a call. Get the caller's permission before putting him or her on hold and thank the caller for holding. Answer calls within three rings. Identify your department and yourself and ask, "How may I help you?"
- **Commitment to co-workers:** Treat co-workers and supervisors as professionals deserving

Baptist Health Care's 'Pillars of Excellence'

Our core strategies are used to develop annual goals and action plans and are aligned with our five pillars of operational excellence. Our five pillars of operational excellence are:

1. **Best People:** Strive to become employer of choice in the market area by emphasizing values-based recruitment, employee and physician satisfaction, retention, and leadership development.
2. **Best Service:** Provide compassionate care and service to all customers at a level that continues to set the highest standards in the health care industry.
3. **High Quality:** Pursue continuous improvement in the quality and efficacy of services provided by all affiliated providers.
4. **Low Cost:** Become the market area's low-cost provider, while optimizing reimbursement for services provided and improving operational efficiency.
5. **Growth:** Continue to achieve growth in scope of services provided, service volumes, and market share.

Source: Baptist Health Care Corp., Pensacola, FL.

courtesy and respect. Welcome newcomers. Avoid last-minute requests and offer to help fellow employees whenever possible. Cooperate with one another. Don't undermine other people's work. Praise whenever possible. Do not chastise or embarrass fellow employees or leaders in the presence of others. Address problems by going to the appropriate supervisor. Be truthful and honest in all dealings, communications, and record keeping.

• **Customer waiting:** Educate families about processes and provide a comfortable atmosphere for waiting customers. An acceptable waiting time for scheduled appointments is 10 minutes. Offer refreshments and an apology if a wait occurs. Always thank customers for waiting. Update family members periodically while a customer is undergoing a procedure.

• **Elevator etiquette:** Always smile and speak with fellow passengers. Hold the door open for others. When transporting patients in wheelchairs, always face them toward the door and exit with care. If transporting a patient on a bed or stretcher, politely ask others to wait for another elevator. Pause before entering an elevator so you do not block anyone's exit. Step aside or to the back to make room for others. Walk departing guests to the elevator.

• **Privacy:** Make sure patient information is kept confidential. Never discuss patients and their care in public areas. Knock before entering. Close curtains or doors during exams and procedures. Provide a robe or second gown if the patient is ambulating or in a wheelchair. Make sure all gowns are the right size for the patient.

• **Safety awareness:** Report all accidents or incidents promptly. Correct or report any safety hazard you see. Use protective clothing, gear, and procedures when appropriate.

• **Sense of ownership:** Take pride in this organization as if you own it. Accept the responsibilities of your job. Adhere to policies and procedures. Live the values of this organization.

By incorporating standards in your daily routine, teamwork, excellent customer service, and our mission of being the best health care system in the country will be achieved. ■

Take a deep breath, now prepare for EDI deadline

Testing already should have begun

Just as health care managers take a breath after rushing to make sure their hospitals are in compliance with the privacy standard, it's time to kick into gear for the upcoming Health Insurance Portability Accountability Act (HIPAA) transaction code-set deadline, which is Oct. 16, 2003.

The HIPAA transaction standard establishes the content and format to be used in the electronic submission of claims and other administrative data between health care entities, including providers and health plans.

Although that deadline is a few months away, **Gillian Cappiello**, CHAM, senior director for access services and chief privacy officer at Swedish Covenant Hospital in Chicago, points out that hospitals were to begin testing their electronic data interchange (EDI) processes on April 16, 2003.

"You have to have a file or something out there to start sending to clearinghouses or [other health care entities]," she says. "We use a company called Nebo Systems Inc. [based in Oakbrook Terrace, IL] for on-line insurance verification and eligibility. It has a product called eCare that puts edits on the billing side. So we have to make sure [that company] is compliant."

Most of what had been holding up progress is that Medicare and most state Medicaid programs were not ready to proceed with EDI, Cappiello notes.

Liz Kehrer, CHAM, system administrator for patient access at Centegra Health System in McHenry, IL, has been focusing extensively on HIPAA compliance preparations.

One of the paths she followed during her research regarding transaction and code-set regulations began with the reference in a HIPAA guidebook to ISO (International Organization for Standardization), the Geneva-based organization that was cited as the source to use for the codes to be used in referring to various countries in electronic health care transmissions.

"Every business that interacts with the processing of the claim must follow a standard format," Kehrer notes. That ensures that all health care entities communicating about, say, the hospital care received by a person on vacation or someone studying abroad, are speaking the same language, she adds. "When submitting a claim, they all must refer to a country with the same identifier."

The most difficult thing about the HIPAA regulations, Kehrer points out, is that they don't explain how to go about doing that. While communicating with her peers across the country on a listserv, she discovered that many were not aware of the HIPAA guide from Washington Publishing Co. that has been instrumental in her preparation: The *National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional* is available at www.wpc-edi.com as either a bound document or an electronic document, she adds.

Using an Internet search engine, Kehrer found that the ISO country codes are kept current by the United Nations, which has a listing of codes and abbreviations on its web site. "We had to go into our computer system and update [the abbreviations] we had, so [communications are accurate] if we have a patient from a particular country who has insurance in that country."

The guide also addresses such issues as what information in the UB92 paper claim needs to be passed over to the electronic claim, she adds. "Another piece is the requirement for the weight of a newborn. Some [providers] may be using pounds, some grams, but remember that because we're standardizing, the information needs to be on the claim in consistent format.

"We're educating the staff in our obstetrics area that when a newborn is registered, the weight is part of that communication," she adds.

The hospital chain HCA recently announced plans to change its charitable care policies to provide financial relief to more of its charity patients and give needs-based discounts to uninsured patients who receive nonelective care at its hospitals. The planned changes, which are subject to approval by the Centers for Medicare & Medicaid Services, would allow patients who receive nonelective care at an HCA hospital and have income at or below 200% of the federal poverty level to be eligible for charity care, a standard it said about 70% of its hospitals already have been using.

HCA also has issued a revised policy on its criteria for filing liens or garnishment of wages of patients who have not paid their hospital bills. The policy prohibits placement of liens on primary homes worth less than $300,000 or garnishment of wages for patients who have a proven inability to pay.

(For information, go to the HCA web site at www.hcahealthcare.com.) ■

More ED crowding seen at large, urban hospitals

Hospitals experiencing the most problems with emergency department (ED) crowding are located in large metropolitan areas with high population growth and a large percentage of uninsured people, according to a recent report by the federal government's General Accounting Office (GAO).

Facilities in areas with populations of 2.5 million or more went on diversion a median of 162 hours in fiscal 2001, compared with nine hours for hospitals in areas with populations of fewer than 1 million people. Hospitals in areas with higher percentages of uninsured had almost twice as high a median percentage of patients leaving the ED prior to medical evaluation, another measure of ED crowding the GAO studied.

While two of every three EDs reported going on diversion at some point during the year, fewer than one in 10 hospitals was on diversion more than 20% of the time.

(For more information, go to www.gao.gov. Click on "For the Press," and enter the document number GAO-03-460 under "Finding GAO documents.") ■

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April 28, 2003

Dear Valued *HCM* Subscriber:

During recent months, the Commission for Case Manager Certification has changed its method for determining the number of clock hours that can be offered for self-paced or home-study activities. As a result, *Hospital Case Management* now will offer up to 13 clock hours per semester.

This change, which will take effect with the current semester, does not reflect any change in the editorial content of the newsletter. *Hospital Case Management* will continue to provide high-quality, in-depth coverage of case management practice that you have come to expect from us.

If you have questions about this change in the number of clock hours offered, please contact our customer service department at (800) 688-2421, or by e-mail at customerservice@ahcpub.com.

Sincerely,

Russ Underwood
Managing Editor
Hospital Case Management