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Hospital's SNF placement initiative improves efficiency, speeds discharge

30% of patients are placed within 24 hours

Before Dartmouth-Hitchcock Medical Center started an initiative to improve the transition of patients to skilled nursing facilities (SNFs), about 12% of the Lebanon, NH, facility's patient days were patients waiting for SNF placement.

Now, three years after a task force tackled the problem, the hospital is experiencing only 5% to 6% of its patient days related to patient wait for a nursing home.

The hospital averages about 100 nursing home placements per month, up from about 80 per month two years ago. About 30% of patients who go to a nursing home are referred and placed within 24 hours.

"We've increased the volume of patients being placed and decreased the number of days we have patients waiting for nursing home placements," says **Sandy Dickau**, RN, MS, vice president of patient and family resources.

The new efficiency has increased hospital capacity. The team has calculated that in the past year, as a result of moving nursing home patients out more quickly, the hospital had capacity for more than 180 patients it otherwise would not have been able to admit.

"We have taken the whole concept of an interdisciplinary team and collaboration to a real state of being," Dickau says.

A task force with representatives from care management and finance, as well as several medical directors looked at ways to increase the efficiency of nursing home placement.

The task force reorganized the care management work by creating a centralized process for SNF placement and involved the physicians in a greater way.

"One of the things we recognized is that we needed to reorganize the work to make it more efficient to handle the patients' transition needs," says Dickau, who chaired the task force.

Before the redesign project, Dartmouth-Hitchcock had inpatient care managers, called clinical resource coordinators (CRCs), who handled care coordination for the patients, utilization management, and discharge planning and were responsible for all SNF placements.

They were assisted by a resource specialist, an RN, who did a lot of the initial contact work with the SNFs.

"Our volume of nursing home patients was really increasing, and it was putting a strain on the CRCs. In addition to handling all the other patient care, they were setting up family meetings and working with the family to help them make a decision on post-discharge care," says **Darlene Saler,** RN, BSN, MBA, director of care management.

The care managers at Dartmouth-Hitchcock are assigned by medical service. Often, three different care managers were calling the SNFs to get three different patients placed in the same vacant bed.

"The lack of coordination meant that sometimes we were competing against ourselves for the same nursing home bed. The resource specialist was trying to make all the contacts and coordinate placements, but she couldn't do everything," Saler says.

The hospital added another full-time resource specialist with a bachelor's degree in human services who works with the nurse resource specialist on nursing home placement.

The resource specialists are dedicated to the SNF placement program and are assisted by a secretary who works with them on behind-the-scenes tasks such as handling paperwork, collecting charts and other information, and doing database entry.

The hospital established a new position of associate medical director for skilled nursing placement. The full-time equivalent position is shared by three physicians.

"Their focus is on the complex patients we had a difficult time placing and creating a bridge between our organization and the community nursing homes," Dickau says.

The task force recommended improving relationships with community nursing homes, an initiative that has resulted in the resource specialists being notified in advance when nursing home beds will be available.

The clinical resource coordinators, resource specialists, and associate medical directors work closely to come up with the best treatment plan for the patients and to decide whether they are more appropriate for an acute rehabilitation center or a SNF.

The managers in the care management department and resource specialists meet twice a week and go through the list of patients, discussing which patients are nearing readiness for discharge, what options are available to meet the patients' needs, and what barriers to discharge may exist.

"We decide who are the priority patients and

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Editorial Questions

For questions or comments, call **Russ Underwood** at (404) 262-5521.

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Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@thomson.com).
Senior Production Editor: **Ann Duncan**.

get one of the associate medical directors involved if necessary to determine if the patient is appropriate for a SNF or should go to acute rehab or even home," Dickau says.

The associate medical directors focus primarily on patients who will be discharged to a nursing home but also work on patients with complex discharge needs who may be discharged with home health.

They communicate closely with the medical directors at the insurance companies and community nursing homes and often facilitate a placement.

For instance, one of the associate medical directors, a physiatrist, convinced the medical director of an insurance company that acute rehabilitation was an appropriate placement for a patient with severe head injuries.

"Without the intervention, the patient would have had to stay here," Saler says.

The associate medical directors work closely with the attending physicians and nursing home medical directors as well. They are particularly effective in helping nursing homes develop a plan of care that allows the patient to stay in the SNF rather than being hospitalized, Dickau says.

In another instance, the associate medical director facilitated the discharge of a patient funded by the Veterans Affairs services. The patient was stable enough to be discharged, but there were no beds for him at the local VA hospital. The Hitchcock staff suggested placing the patient in a nursing home, but the VA balked at paying for transportation for the patient to come to the medical center for dialysis.

The associate medical director intervened and got the patient moved.

"It just took moving it to that next level to get the physician at the VA to hear what our doctor had to say," Saler says.

Last spring, clinical resource coordinators began staffing the emergency department (ED) and at times have been able to place a patient directly to the nursing home from the ED.

The ED CRC may start the discharge plan, discussing placement options with the patient and the family in the ED.

If the patient is admitted, the CRC covering that inpatient service is responsible for initiating the plan.

"We start looking at nursing home placement when we know it may be an issue for the patient. The timing depends on a lot of factors," Saler says. "If a patient has not been doing well at home, we might suggest that the family consider a SNF early on."

As the new system progressed, the Dartmouth-Hitchcock team has identified several areas for improvement.

For instance, the hospital created a referral form to alert the resource specialists of potential SNF placements.

"We get them on the list even though we know it may be weeks or days before we need a placement," Saler says.

The new efficiency and quick referral to nursing homes puts an extra burden on staff to help patients and families adjust to the idea, she added.

"We are looking at ways we can do a better job of letting patients and families know up front that this is a possibility," she adds.

The staff created a booklet for patients and families, listing all the possible discharge options.

"It took a lot of work to make this information inclusive and complete. We make sure we get it to all the patients and families early on so they can see that there are a lot of very different options and so they can understand the Medicare regulations around nursing homes," she adds. ■

Close relationship with SNFs benefits both parties

Hospital, nursing home staff collaborate

When Dartmouth-Hitchcock Medical Center in Lebanon, NH, undertook an initiative to improve the efficiency of nursing homes admissions, the task force looked at ways to improve communication and collaboration with local skilled nursing facilities (SNFs).

The hospital invited the medical directors of the local SNFs to a retreat attended by the care management staff and the hospital's associate medical directors and asked them for a frank discussion of how the process could be improved.

"We gave them the opportunity to tell us their complaints and issues, and we came up with a healthy list. Now we're working to smooth some of the issues out," says **Sandy Dickau**, RN, MS, vice president of patient and family resources.

They looked at barriers to admitting patients to the nursing home, problems with transition, and how the SNF staff and the hospital staff could

collaborate to improve them.

For instance, the nursing home staff complained that they were being asked to take patients who were on very expensive medications that the nursing homes couldn't afford to cover.

"We are a teaching center, and our doctors often use the latest and greatest drugs, but the nursing homes can't afford that kind of medication costs," Dickau says.

The SNF team is working with the physician staff to help them understand the cost of the drugs and to make sure they consider potential alternatives.

The nursing home medical directors complained that they didn't feel as though they were getting enough complete information on the referral and often asked the hospital to fax the entire chart, a job that is time-consuming for staff.

The hospital developed a uniform referral form with all the information the nursing homes agree is important. It cut down copying to a minimum.

The nursing home administrators cited problems in filling prescriptions and getting supplies if physicians changed patient orders the day of discharge.

"We're a tertiary medical center and have access to everything 24 hours a day. We forget that the nursing homes have different contracts for pharmacy or medical supplies, and if we change the order at 1 p.m. and the patient gets there at 3 p.m., they don't have a way to get the new medication or dressing," says **Darlene Saler**, RN, BSN, MBA, director of care management.

The hospital now makes every effort not to make changes in the plan of care at the last minute.

"We are in a unique position to hear feedback from the nursing homes and to find out where we need to focus our resources. It has been very helpful for our staff to understand and appreciate what the nursing homes go through," Saler says.

As a result of the meeting, the hospitals and nursing homes tackled ways to improve the handling of patients who have a bacterial infection and need to be isolated.

They convened a meeting of the hospital's infectious disease staff, skilled nursing facility staff, and state health officials to look at the needs of the patients and how to work together to protect them.

"One of the wonderful outcomes is that we were able to influence the state in updating regulations. Through education, the nursing homes better understand the precautions and why they are handled the way they are," Dickau adds.

As a result of the increased communication, some nursing home officials have asked the hospital for guidance in whether they should specialize in caring for a particular type of patient in order to fill their beds.

"They've asked us what kind of patients we find most challenging to place. They are trying to find their niche," Saler says.

In return, the hospital works to provide resources to help the nursing homes care for their challenging patients.

For instance, one facility has expressed an interested in taking more pulmonary patients. The team has identified a pulmonary nurse who is agreeable to educating the nursing home staff on caring for pulmonary patients.

"We can use our own staff to do education and to provide resources the nursing homes don't otherwise have access to," Dickau says. ■

Documentation initiative pays off for hospitals

Care managers perform intensive concurrent review

Since Hurley Medical Center in Flint, MI, began a comprehensive program to improve documentation, reimbursement has improved and the hospital's severity of illness and risk of mortality data have come in line with benchmark data.

"Before we started this initiative, when we compared our case mix index to benchmarks, it appeared that the patients at our hospital were not as sick as other patients but they had a higher risk of mortality and longer lengths of stay," recalls **Teresa Bourque**, RN, BSN, senior nurse care manager the medical center.

Hurley Medical Center is a Level 1 trauma center with a high-risk birthing center and a neonatal intensive care unit. It serves a large indigent population.

"It didn't seem right that our severity of illness and risk of mortality were off the mark for our lengths of stay," Bourque says.

The hospital hired an outside vendor, 3M Health Information Systems, based in Salt Lake City, to assess what was needed to improve clinical documentation, to train physicians, nurses, nurse care managers, coders, and utilization

management coordinators and to provide software to manage health care data.

"We use the information we learned in class to help with our mission of better documentation, decreasing the lengths of stay, and making sure the patients can be safely discharged," Bourque says.

The initiative went live January 2003.

Before the new program, when care managers or utilization coordinators reviewed the records, they were looking for severity of illness to indicate that the patients met the criteria to be in the hospital.

"Now we look more thoroughly at the patient records — not just the progress notes but the anesthesia records, intraoperative notes, the nursing notes, laboratory results," Bourque says.

The care managers conduct a concurrent review of records looking for clues that might indicate a problem area in coding. The goal is to review patient charts within one day after admission.

"The purpose isn't just to improve revenue. We want to document that our patients are really sick and to make sure their conditions are properly documented," she says.

The inclusive picture of the patients

This initiative has expanded the nurse care manager role in looking at the inclusive picture of the patient, Bourque says.

For instance, they are looking at radiology reports — not just at admission but those that come in during the stay. They look at laboratory results, comparing those when the patients were admitted to later results.

"We find instances when the patient's labs looked fine when they came in. Later on, the results show that their protein level is going down because they're not eating sufficiently. This may perhaps suggest malnutrition as a complicating process. Then we know it's time for a nutrition consult," she says.

The care managers examined the diagnosis-related groups (DRG) in which Hurley's patients' lengths of stay exceeded the benchmark lengths of stay and scrutinized the records to see why.

Here are some of their findings:

- **Chest pain.**

The care managers found a number of patients who were being admitted to the hospital with a diagnosis of chest pain when they actually had coronary disease.

"We make sure there is proper documentation of the underlying condition. In these instances, the chest pain may be more accurately related to anginas opposed to nonspecific chest pain," she says.

- **Trauma cases.**

The care managers focused on trauma cases to see if patients with significant trauma were in the correct DRG.

"If they have multiple trauma, that puts them in a higher-weighted DRG, but often it didn't indicate that in the chart," Bourque says.

- **Neonatal care.**

According to benchmarks from the Centers for Medicare & Medicaid Services (CMS) some patients in Hurley's neonatal unit were coded in a DRG that indicates a four-day stay but were staying seven or eight days.

"We closely scrutinized the records and determined that the documentation supported that these patients should be in a different DRG. When the patients were coded correctly, our DRG was not off-base compared to the benchmarks," Bourque adds.

- **Sepsis secondary to a urinary tract infection.**

Some patients with severe urinary tract infections were in the intensive care unit because they were in septic shock, but their charts were coded to indicate simply a urinary tract infection.

"Patients aren't admitted with urinary tract infections. These patients were on IV antibiotics. This is another example where the proper documentation is important," Bourque says.

The care managers and coders meet monthly to discuss some of the cases, look for patterns in which the incorrect DRGs are coded, and come up with ways to improve the documentation.

For instance, there was a problem with coding guidelines for exploratory laparoscopy followed by surgery or other procedures. Sometimes the physicians were using only the exploratory laparoscopy coding instead of the procedure coding.

The coders presented the information to the care managers, who took it to the physicians.

"We are looking at the data we get on our DRGs and comparing them with our lengths of stays. We use the data to see if we need to address outliers whose lengths of stay are longer than average or if they are really sick patients who need to be here," she added.

The purpose is to make sure clinical resource utilization is properly documented to allow assignment of patients to the appropriate DRG, Bourque points out.

Because the care managers were spending more time with the charts and less with the patients, they called on the hospital social workers to pick up some of the patient time and depend on nursing to alert them when a patient's needs call for more intensive care management.

The hospital revised the admission assessment to include triggers for care management on patient needs.

"The care managers initially felt they didn't know their patients as well. We have found that it helps with the documentation piece to go into the room, talk with the patients, and find out what's going on," she says.

For instance, if the care manager visits a patient and notices that the patient isn't eating, he or she can alert the physician.

Hurley's care managers work more closely with physicians under the new system. "We aren't just looking at patients' discharge needs but also documentation and the patient record."

When the nurse care managers finds something in the chart that is not clear, they ask the physician for clarification. Most of the queries to physicians are written and placed into the progress note section of the chart. They are not a permanent part of the chart. Sometimes the care managers make a verbal inquiry about documentation to the physicians and encourage appropriate documentation of the clarification in the medical record.

For instance, the patient might be prescribed albuterol and an inhaler, but there isn't documentation of a diagnosis that is associated with those treatments.

"When we speak with the physicians, we suggest several DRGs that maybe the patients should be assigned to with the various assigned weights. We meet with the physicians to see if there is something they are seeing about the patient but are not writing in the chart. We work with them to get the patient into the appropriate DRG based on the proper documentation of clinical resource utilization," she says.

The hospital's chief of staff and vice president of medical affairs are involved in the process and can approach physicians to discuss individual issues.

Bourque goes to the medical staff meetings and presents her findings to the physicians.

The queries that care managers send to physicians about documentation are phrased so they can be answered "yes" or "no." "At last report, 98% of the questions the physicians answered were answered with a 'yes' with regard to proper DRG assignment," she says.

The physician response to the documentation questions has been less than 50%. The goal is to get up to a 75% response.

The software used by Hurley Medical Center to track documentation and DRG assignment contains a worksheet documenting the questions sent to physicians. The care management department conducts reviews to determine how many care managers are asking questions and how many physicians are responding to the questions.

"We can break out data by physician and by care manager and determine if the physician responded by coding along the lines the care manager was thinking of or if they went in a totally different way. We make sure the clinical documentation supports the coding," she says.

Every three months, the 3M consultants do a data review follow-up with the medical center based on the information they get from the weekly reports of coding.

"They get the reports on a weekly basis just as we do. We pull certain diagnoses and review the record to makes sure the coding is on target and ensure there are no missed opportunities," she says.

If there are areas that need improvement, 3M provides benchmarking based on other hospitals.

"It's a very good program. It's very thorough, and it gives the care managers an opportunity to see the revenue side of the hospital. This is particularly important with patients who have a long length of stay. If a patient is very sick, you want to make sure there is correct documentation to support proper reimbursement for the services they get while they're here. If they are going to have an extended stay, we should get paid for it, and the only way to do that is to document properly," she says. ■

New program helps breast cancer patients

Successful pilot becomes full-time program

A case management program for newly diagnosed breast cancer patients at MeritCare Health System in Fargo, ND, helps women smoothly navigate through the health care maze as they make treatment decisions.

(Continued on page 191)

CRITICAL PATH NETWORK™

Flowcharts are basis for symptom-based tools in the ED

Health care providers have access to plenty of flowcharts and algorithms designed to guide the treatment of patients with particular diagnoses, but many of them aren't designed for use in the emergency department (ED). What good is a flowchart for pneumonia if you don't know what's wrong with the patient yet?

To address that problem, the ED team at Overlook Hospital in Summit, NJ, has developed what it calls "flow-gorithms" for commonly seen illnesses.

The difference between the flow-gorithms and the other tools commonly available is that the flow-gorithms are symptom-based rather than diagnosis-based, says **Patricia Gabriel**, RN, BSN, CEN, nurse manager of the ED. "All of the things we look at in terms of pathways and patient management are all diagnosis-driven. That doesn't help us from an ED perspective because patients don't come in with labels that say, 'I have pneumonia.'"

The flow-gorithm is a symptom-driven tool that guides the entire ED team — physicians, nurses, and others — to a proper diagnosis and ensures that the best testing and treatment are provided along the way.

The flow-gorithm is fairly simple in design and easy to use, Gabriel says. It looks much like a typical flowchart that leads the user from one step to the next, depending on the patient's symptoms, she says.

The triage nurse usually is the first to use the flow-gorithm and matches the patient's symptoms to those listed at the top of the flow-gorithm. For example, if the patient reports fever, cough, shortness of breath, and increased sputum, that fits the pneumonia flow-gorithm, and the triage nurse will attach a copy to his or her chart.

When patients come in by ambulance, they bypass the triage nurse and go directly to an exam room. In that case, the nurse responsible for that room initiates the flow-gorithm. **(See sample flow-gorithm, p. 184.)**

The flow-gorithm gives specifics as to whether the patient should be triaged as emergent or urgent, and lists other steps and questions for others. Some steps have spaces to initial and indicate the time that an action was taken. At several points, the results of the examination may lead the clinician out of the decision tree by indicating that the patient does not have pneumonia and should be treated accordingly.

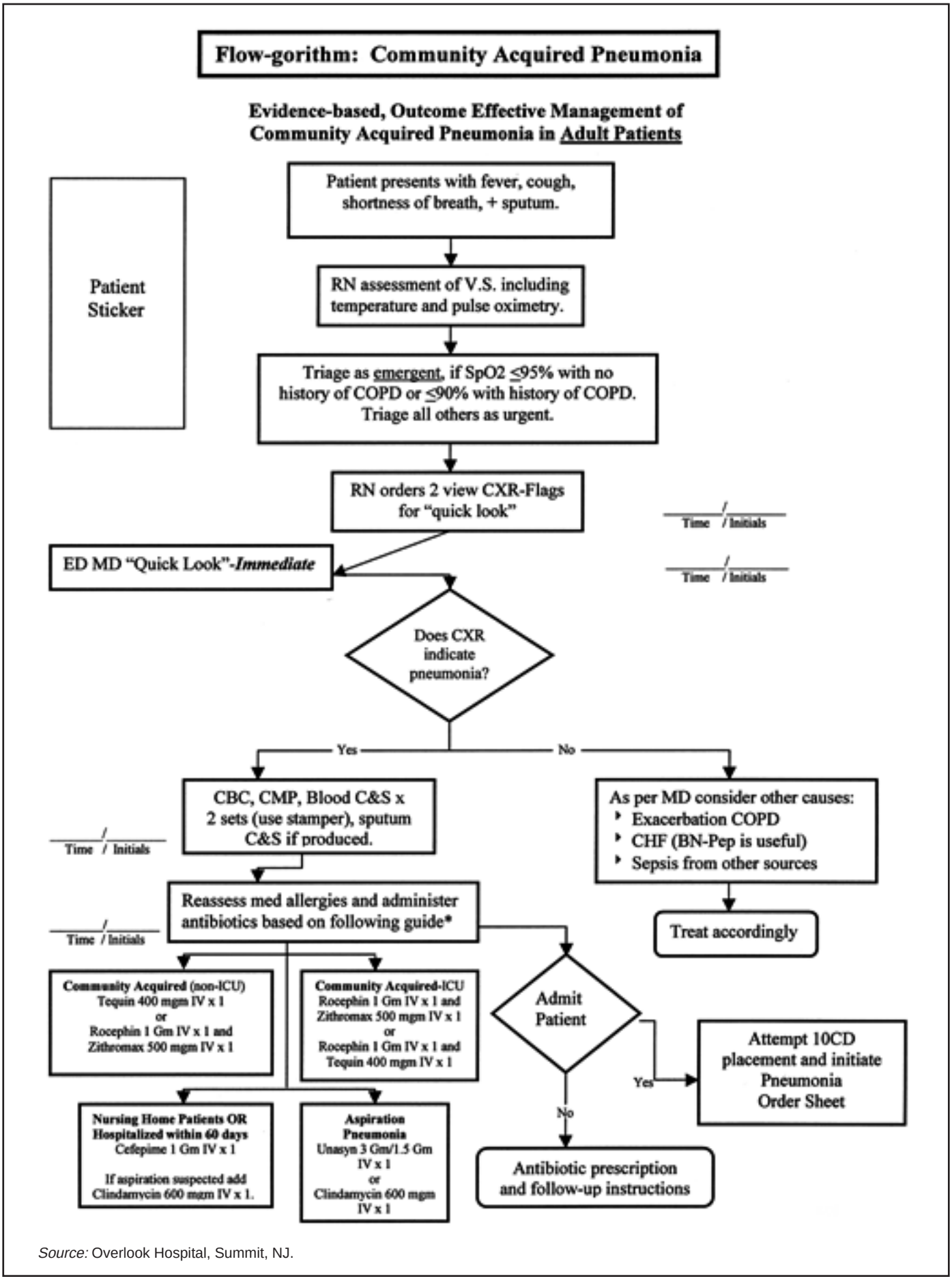
"It lets you work through the symptoms and processes without always having to have physician input up front," she says. "Then if the physician says the X-ray shows pneumonia, we use the flow-gorithm to tell them what blood work needs to be done and which of the antibiotic groups they can pick from."

The first flow-gorithm, for pneumonia, was developed about four months ago, and then the team developed one specifically for geriatric pneumonia. A flow-gorithm for chest pain was developed more recently, and the team plans to develop one for potential stroke patients.

Pneumonia was a good place to start because its symptoms are clearly defined and straightforward, Gabriel says. The ED team also wanted to improve the way it treated patients presenting with suspected pneumonia. "We have a strict time frame to give them antibiotics — just four hours from presentation," she says.

"On a busy day in the ED, if a middle-aged person comes in with cough and fever, and the pulse oximetry was alright, they were not going to be high on the list for acuity. If you don't get the

(Continued on page 185)



Source: Overlook Hospital, Summit, NJ.

chest X-ray done right away, the clock is ticking, and you're not going to get the antibiotics to them in four hours if it does turn out to be pneumonia."

The team also found that elderly patients often slipped through the system and didn't get antibiotics in time because their pneumonia presented with very different symptoms than the average patient. "If you fell in the 18 to 65 range, almost 100% of the time, you got your antibiotics within four hours," she says. "If you were in the 65 to 85 range, maybe 65% of the time you got your antibiotics within four hours. If you were 85, forget it. You didn't get your antibiotics for a while because you didn't present with symptoms that we recognized as pneumonia."

So the flow-gorithm for geriatric pneumonia includes "change in normal activity tolerance" as a symptom that should trigger the use of the flow-gorithm. "If the patient presents with that, that automatically moves them up on the list and we order a chest X-ray," Gabriel says.

The flow-gorithms are based on commonly accepted practice guidelines, but they also are tailor-made to the needs of the Overlook Hospital ED staff. For instance, the flow-gorithm for chest pain addresses a common problem that the staff encountered concerning how much aspirin to administer. No one could ever remember whether to count the patient's daily aspirin dose or aspirin administered by the paramedics when figuring the dosage. "So it says right on there to give aspirin unless they got a certain amount from the paramedics," Gabriel says. "And it says to give the aspirin even if they took their normal maintenance aspirin."

[For more information, contact:

- ***Patricia Gabriel**, ED Nurse Manager, Overlook Hospital, 99 Beauvoir Ave., Summit, NJ 08043. Telephone: (908) 522-2000.]* ■

Stroke centers can cut LOS, boost outcomes

Complicated process needs multidisciplinary team

Stroke centers with specialized stroke teams have the potential to improve outcomes and decrease lengths of stay (LOS) for facilities that previously have relied solely on pre-hospital and emergency department (ED) infrastructure.

This certainly has proven true at the University Hospital of Cincinnati, which was one of the pioneers in establishing a stroke center. "We have been treating [stroke] patients aggressively since the late 1980s, which is very unusual," says **Arthur M. Pancioli**, MD, FACEP, associate professor of emergency medicine and vice chairman of the department of emergency medicine at the University of Cincinnati College of Medicine, who came to the facility in 1991.

"It all comes down to the fact that stroke is a very complicated disease process and requires a multidisciplined team," he explains. "It has been shown many times in the literature that a formalized stroke team provides better care."

In many ways, the most appropriate way to treat stroke is no different than the optimal way to treat any complicated disease process, Pancioli continues. "A classic example is trauma, where you have a dedicated center," he notes. "So much of the modeling is similar, although the disease processes are vastly different."

Pancioli notes that over the years, the Cincinnati stroke center has improved outcomes, decreased mortality, and reduced morbidity. "Clearly, organized systems are going to have reduced length of stay relative to acuity. Quite often, major centers have longer lengths of stay than those centers that treat patients of lower severity, but relative to statistics that are adjusted for stroke severity, the patients [treated by stroke centers] do better."

In the mid-1990s, for example, Cincinnati compared its LOS data to its typical benchmarks such as UCLA. "With a typical team, we were able to reduce length of stay relative to our benchmark partners in that particular system," he says.

In many institutions, Pancioli notes, a stroke center is more of a system and a team than it is an identifiable, physical place within the facility.

"Very few places have a geographically located stroke center," he says. "Rather, you have a multidisciplined team, a defined champion, and representatives from all the important disciplines. The organization of the group is vastly more important than [having] four walls."

Bearing that in mind, one of the keys to the success in Cincinnati is that "we have an absolutely marvelous neuroscience department here," says Pancioli. In addition, there is the emphasis on multidiscipline care. At Cincinnati, that includes neurology, emergency medicine, radiology, neurosurgery, PT, and rehab, occupational therapy, speech therapy, nutrition, social work, which is absolutely critical, he says; "and, of course, nursing care has to be dedicated to the cause."

Then there is the actual response protocol. "One thing that's getting an awful lot of attention now is

first being capable of taking care of acute patients," Pancioli points out. This requires complex decision making that must be done rapidly. "For that, we have a long-established acute stroke team so that '24/7' one of our physicians is immediately available by page," he says.

"One number goes to all the team, then there is a signal back that the doc has received the page and responded that he either will treat, or that he is occupied and is a no-go. Also, the whole team knows the call went out and when a response signal has not come back. If a second signal comes without response, we all call back. In any event, you need the availability of a primary consultant who can assemble the whole team."

On an ongoing basis, there is a team in-hospital that meets regularly to address the stroke team census, the progress with each patient, and what is going on with the acute stroke population in the hospital. When it comes to recovery, "That's where we have to have significant coordination and communication between the physicians, the nurses, and everything in between," Pancioli says.

The pathway for acute stroke care is an essential ingredient in the formula for success, he says. "In an ideal world, when the patient hits the door, the pathway is put with them."

Pancioli is a firm believer in written protocols. "People who consider pathways or protocols to be 'cookbook medicine' ought to be saying, 'I like to individually forget individual things for individual patients. What a protocol provides is a way of not forgetting anything. We are all human — we all forget things. Simply put, a recipe makes sure all the right ingredients end up in the pot." In treating stroke patients, it is critically important to "do the things that you know affect mortality," he says. "It's like treating an MI and making sure the patient got an aspirin, and if not, why not."

For example, the stroke team checks items such as if patients went home on anticoagulant medicine, if dysphagia screening was done before they started to eat, if they received some form of DVT/PE prophylaxis, and so on. "After all, we know it kills people," Pancioli says. "You look at the things that have a literature basis for improving mortality and reducing morbidity, and you count."

At Cincinnati, tools such as the Paul Coverdale Registry Data collection forms and the Centers for Medicare & Medicaid Services' Fixed Scope of Work are relied on. "These are things benchmarkers should be looking at," he asserts.

Getting a stroke center up and running and making it successful is easier than it looks. "I've been part of a number of initiatives to take stroke centers 'to the streets,'" Pancioli says. "It's difficult to do because you have to change a behavioral paradigm. You have to motivate people, explain why a stroke center is beneficial, and ask for resources. If you can find a stroke champion, show the literature, explain the benefits, and find a good protocol [there are many available on the web, he says] and get everybody at the table, you'll win."

[For more information, contact:

- ***Arthur M. Pancioli**, MD, FACEP, Associate Professor of Emergency Medicine, Vice Chairman, Department of Emergency Medicine, University of Cincinnati College of Medicine. E-mail: Arthur.pancioli@uc.edu.]* ■

CE *questions*

21. At Dartmouth-Hitchcock Medical Center in Lebanon, NH, what percentage of patients who go to a nursing home are referred and placed within 24 hours?
    A. 25%
    B. 30%
    C. 40%
    D. 45%

22. At a retreat held by Dartmouth-Hitchcock Medical Center, medical directors of local skilled nursing facilities and the hospital's care management staff and associate medical directors discussed which of the following issues?
    A. new EMTALA regulations
    B. HIPAA business associate agreements
    C. problems with transition
    D. all of the above

23. When do breast cancer case managers at MeritCare in Fargo, ND, make the first telephone call to the patients whose care they manage?
    A. within a few minutes after diagnosis
    B. after the surgical consultation
    C. within a week after diagnosis
    D. following surgery

24. What was the primary reason that the ED team at Overlook Hospital developed what they call "flow-gorithms?"
    A. so staff could use a tool that is symptom-driven
    B. so staff could use a tool that is diagnosis-driven
    C. because no clinical pathways were available for treating pneumonia
    D. because no clinical pathways were available for chest pain

Answer Key: 21. B; 22. C; 23. A; 24. A

AMBULATORY CARE
QUARTERLY

Research shows ED case management saves dollars

Update of pivotal study shows cost savings

Researchers are set to release new data confirming the benefits of a case management strategy heralded three years ago as a way to decrease the cost of treating repeat patients in the emergency department (ED). The program first piloted in a California hospital has been used at several others in the interim, and the researchers say the results are encouraging.

The study gained widespread attention in 2000 because it suggested that a system of intensive case management could reduce the financial burden associated with the indigent patients who show up in the ED over and over again. Though many ED managers liked the idea, there was some skepticism about whether the strategy was practical.

Those questions were justified, but the latest data are showing that the plan works, says **Alicia Boccellari**, PhD, director of the division of psychosocial medicine at San Francisco General Hospital and the University of California, San Francisco School of Medicine.

Boccellari was the lead researcher in 2000 and plans to update the study at the upcoming meeting of the American Public Health Association in San Francisco.

A randomized treatment trial of 300 people has been completed, with two-thirds receiving intervention and one-third receiving usual care. The preliminary results look very strong, she says.

"Our first report was a pilot study, and you always wonder if that will hold up under a randomized trial," she says. "It does appear that the results in the randomized trial are very similar to those in the pilot. Those patients randomized to clinical case management did show the same results: decreased ED visits, hospitalization, and homelessness."

The original study examined the impact of case management on hospital service use, hospital costs, homelessness, substance abuse, and psychosocial problems in frequent users of a public urban ED.[1] The subjects were 53 patients who used the ED five times or more in 12 months.

Utilization, cost, and psychosocial variables were compared 12 months before and after the intervention. The median number of ED visits decreased from 15 to nine, median ED costs decreased from $4,124 to $2,195, and median medical inpatient costs decreased from $8,330 to $2,786. Homelessness decreased by 57%, alcohol use by 22%, and drug use by 26%.

Through the case management services, 54% of medically indigent subjects obtained Medicaid. There was a net cost savings, with each dollar invested in the program yielding a $1.44 reduction in hospital costs.

"Case management appears to be a cost-effective means of decreasing acute hospital service use and psychosocial problems among frequent ED users," the researchers conclude.

Since the pilot study, the case management strategy has been adopted at about 10 hospitals across the country, Boccellari says, and two foundations in California recently announced plans to fund more of the programs in that state.

The California Endowment in Woodland Hills and the California HealthCare Foundation in Oakland, two private, statewide health foundations, recently announced the launch of the Frequent Users of Health Services Initiative, a five-year, $10 million program aimed at creating a cost-effective health care delivery system for uninsured Californians.

Melissa Welch, MD, project director for the initiative in Oakland, has had firsthand experience addressing the needs of frequent-user patients as the former chief medical officer for the Community Health Network in San Francisco, which serves the indigent. She says Boccellari's strategy can be cost-effective.

The Initiative endorses the method as a way for hospitals to save money while improving care

for the uninsured, but Welch says it isn't a project to undertake without a serious commitment. The approach requires a high degree of collaboration between case managers and the ED.

Though the latest data suggest the savings are real, they may not be what all ED managers are looking for, Boccellari points out. There are downsides to consider before jumping in, she says.

Welch notes that because some ED savings are not "extractable," meaning ED visits have decreased but it doesn't affect the fixed costs of the hospital, it can be difficult to apply those savings to the expense of case management.

Boccellari agrees, saying there is some concern that even if you have a cost offset, it may not appear on the bottom line. "You're likely to reduce utilization, but it's not like the hospital is all of a sudden making a profit." Also, this program is very labor intensive, she says. "You need incredibly tenacious case managers who are willing to work with some of the most difficult patients."

It may take six months to see results from the program, but Boccellari says it can help improve morale among ED staff who feel frustrated with seeing the same difficult patients repeatedly. There also is the possibility of direct revenue generation, she says.

"Through this program, we were able to get many of these patients on entitlements so the hospital could bill Medi-Cal and get reimbursed for the care," she adds.

Previously, they had no benefits, and the county had to pick up the bill for all of their care, Boccellari says. "So there can be a revenue enhancement, not just a cost offset," she says.

Reference

1. Okin RL, Boccellari A, Azocar F, et al. The effects of clinical case management on hospital service use among ED frequent users. *Am J Emerg Med* 2000; 18:603-608. ■

Resource drive for ED nurses saves $12,000

Wouldn't you love for emergency department (ED) nurses to have a quick, easy way to access department policies, updates, drip charts, dosing protocols, telephone numbers, and procedures for infrequent ordering processes?

"Access to many tidbits of information that ED nurses and staff members need to memorize and quickly access remains a constant challenge for me," says **Sharon Wysocki**, RN, MS, clinical specialist for the ED at Northwest Community Hospital in Arlington Heights, IL.

To address this, a computerized resource drive was created that can be accessed by all ED staff. "There is now one easy location for the multitude of information we receive," she reports. "This has contributed greatly to the organization and management of information."

While the ED leadership has "write-ability" access, most staff have "read-only" access, Wysocki explains. She estimates that nurses are able to care for patients an additional hour each day that otherwise would be spent looking up information, saving the ED a minimum of $12,000 each year.

Information contained in the drive includes:

- Instructions for ordering infrequent lab tests and equipment.
- Information on severe acute respiratory syndrome from the facility's infection control department.
- Updates on monkeypox, a rare illness that causes rash, chills, and fever.
- Hazardous material procedures.
- ED standing medication protocols, standing orders, and assessment protocol.
- Education tracking file containing expiration dates for certifications of ED nurses, including Trauma Nurse Core Curriculum, Crisis Prevention Institute training, advanced cardiac life support, pediatric advanced life support, and cardiopulmonary resuscitation. "This is a great help, as nurses can easily access this drive to verify their expiration dates," Cohen says.
- Listing of the facility's trauma categorization criteria.

Nurses appreciate having easy access to the enormous amount of information they need to reference, says Wysocki. For example, for infrequent procedures such as initiating patient-controlled analgesia, the ED nurse can quickly access information on the ordering process.

Recently, when a patient arrived stating he was exposed to monkeypox, the ED nurse and physician used the drive to determine what to order and what type of isolation precautions were needed.

"We are constantly making additions and updates to our resource drive," Wysocki says. "My challenge remains to keep it simple and user-friendly. It is not intended to be a duplication of the entire department policy and procedure manuals."

Since information is located in one convenient place for all staff to access, this eliminates various additional policy books, reference material, and the need to manually update all of the pages in these references, even when simple changes occur, Wysocki says.

Getting updates to the staff without making numerous copies of everything and distributing to their mailboxes, she says, saves time and money.

"Staff are always complaining there is too much paperwork and too much to read," adds Wysocki.

[For more information, contact:

- ***Sharon Wysocki**, RN, MS, Clinical Specialist, Emergency Department, Northwest Community Hospital, 800 W. Central Road, Arlington Heights, IL 60005. Telephone: (847) 618-1000, ext. 4063. Fax: (847) 614-4098. E-mail: SWysocki@NCH.ORG.]* ■

Get a handle on claims denials with database

Denial rates affect reimbursement

If you think your hospital doesn't have a problem with denials, then you aren't doing enough to track them, says **Christine Collins**, CHAM, director of patient access for Brigham & Women's Hospital in Boston.

The heart of successful denial management, she emphasizes, is a denial database that categorizes the bills that are denied and the reasons why.

With the challenges of clinical vs. administrative denials, observation vs. inpatient status denials, and complicated time-sensitive authorization processes, she adds, the cash flow can be difficult to follow.

To get a handle on what wasn't getting paid and why, the hospital formed an inpatient denial team — co-chaired by Collins and a physician — to oversee the process, with representation from patient access, billing, medical records, and care coordination. Boston-based Partners Healthcare system, of which Brigham & Women's Hospital is a member, awarded the team a 2001 Partners in Excellence Award for outstanding efforts in improving management of denials. Collins says the team continues to be recognized for its achievements.

Building a denial database was the first order of business, she says. An analyst in the patient access department provides upkeep of the database, while other functions are handled by the following areas:

- Care coordination provides analysis of clinical/utilization review denials.
- Patient access assesses authorization processes.
- Patient accounts pursues final outcome.
- Medical records handles documentation needs.
- Medical director handles clinical appeals.

The process begins, she explains, when accounts receivable gets a denial and puts it into the database, assigning it to a person based on the kind of denial it is.

"What we do that's wonderful is assign denials so we can track them. If [a denial] comes to my office, but is clinical, I reassign it to a person who can handle it," Collins notes. "If it's a pre-cert or pre-authorization [issue], it's assigned to my staff."

"Most hospitals," she adds, "don't have the IT [information technology] to have this information at their fingertips — [information about] who's working what."

Pat O'Keefe, denial manager in patient access services, is in charge of handling all technical and administrative denials, Collins says, and at times works very closely with care coordination personnel. "In every area, care coordination has one or two people who own this [denial management] process."

O'Keefe says she consults with utilization review nurses to determine whether a patient has inpatient or observation status, which often is a point of contention with insurance companies responding to claims.

On a day-to-day basis, O'Keefe notes, she is responsible for researching any [technical and administrative] denials that are related to inpatient admission. "[That includes] writing the appeal and getting any kind of documentation I need to support our case, [including] screen prints of notes saying who we spoke to [at the insurance company], what authorization number we got, and also getting any necessary medical documentation, and sending it off to the insurance company," she says.

Even in the case of technical or administrative denials, O'Keefe says, many insurance companies require that a patient's medical record accompany the appeal. "I have a spreadsheet that I've developed, and every time I send out an appeal, I enter it on the spreadsheet so I can keep a running total, including what the status is, if an appeal is still out."

Collins is reluctant to make before-and-after comparisons regarding dollars recouped by the denial management initiative. A reimbursement denial that's now quickly reversed via the new denial management process eventually might have been handled successfully through appeals, she points out.

"[In the past], if we had these denials and weren't tracking them but did a lot of legwork and eventually got paid anyway, it might have taken six months instead of six weeks," Collins says. "In the old days, and still at many hospitals, people in accounts receivable are constantly resubmitting bills."

The beauty of the tracking process, she adds, has been in the ability to notice trends, improve processes, and work with payers on better system-to-system communication.

"Data are so powerful," Collins notes. "Until you have that, you're looking at [denials] one by one. Once we track them, we have the documentation to support why we shouldn't have been denied. Settlements with payers can be made based on data. We maintain all the documentation on-line, and we follow up denied claims until resolution."

Within the database, there is the capacity for electronic communication to prompt steps in the appeal process, she says. "If we notice that something is a trend and should not be a denial, we can include that in the next contract negotiation."

Examining individual problems can lead to long-term solutions in other areas. Some redundancies in the preauthorization process can be beneficial to the payer as well as the hospital, she points out. "They want to make their administrative burden smaller, too."

While in the past, a payer might contend that the hospital never had made a preauthorization call on a particular case, the capacity for electronic communication puts the accountability on both sides, Collins points out.

"When we start to do an autopsy on denials, we say, 'Gee, their system has its own problems.' Sometimes, what we have here is different from what they think. If you don't dot an I on one system, the other system kicks [the bill] out," she says.

"When we first started doing appeals, [the payers] had not had a lot of hospitals doing them," O'Keefe adds. "It would take five months or longer for them to acknowledge that we'd sent an appeal. Then they would send a letter saying we would be notified in 45 days."

Tracking denials prevents certain groups of patients from slipping through the cracks in the admitting/screening process, she notes.

What Brigham & Women's system provides, Collins points out, "is more understanding so we can improve our process. Until you have a common, integrated database that is completely open, honest, and hospitalwide, you're not going to have that. It's the little things. It's truly understanding the business, and what the issues are, and [asking] how can we fix them."

[For more information, contact:

- ***Christine Collins**, CHAM, Director of Patient Access, Brigham & Women's Hospital, Boston. Telephone: (617) 732-7453. E-mail: cfcollins@partners.org.*
- ***Pat O'Keefe**, Denial Manager, Inpatient Access Services, Brigham & Women's Hospital. E-mail: pokeefe@partners.org.]* ■

(Continued from page 182)

The program started out as a pilot project in January 2002. The response from patients and staff has been so good the health system has made the job a full-time position.

"They have realized what it has done in the way of patient satisfaction and in helping to streamline the care," says **Linda Sveningson**, RN, MS, AOCN, breast cancer case manager at MeritCare.

At MeritCare, breast cancer case manager is one full-time equivalent position shared by two master's-prepared nurses.

The nurses have an active caseload of about 45 patients, 20 of whom are new patients and the rest of whom are going through surgical treatment.

In a typical month, Sveningson actively works with about 45 patients. About 20 are new patients who have just gotten a breast cancer diagnosis. The rest are those she is following through surgery.

"I'm the person they can call to point them along the way and give them any information they need," she says.

Education begins with the initial diagnosis

Sveningson is based in the radiology portion of the breast clinic, where many patients get the first information about their diagnosis.

She calls patients within a few minutes after the radiologist calls to tell them their breast biopsy is positive.

"I am there to provide support and education and to coordinate the appointments they will need," Sveningson says.

"These patients are in an absolute state of shock. On the first day, I answer their most urgent questions and call them again the next day to talk further. The next day, they want to know what it means. On the first day, they're just blown out of the water by the diagnosis," she says.

Sveningson reviews the pathology report with patients and sends them packets of information about breast cancer and treatment options.

"I can meet with them in person, but since so many live a distance away, I do a lot of work on the telephone," Sveningson says.

The health system serves a large rural community in parts of North Dakota, South Dakota, and Minnesota, and some of the women who come to the clinic live as far as 200 miles away.

Sveningson does an initial intake assessment and enters the information into the health system's computerized charting system. The assessment includes their concerns and goals and any barriers to appointments.

"The surgeon can look at the information and know what we know about the patient," she says.

Depending on the diagnosis, patients may need a surgical consultation or a medical oncologist consultation. Sveningson helps set up an appointment and coordinates, whenever necessary, with the patient's primary care physician.

Before the program started, patients would get the initial diagnosis and then have to wait seven to 10 days to see a physician for follow-up.

Navigating the information maze

"They would get information from friends or go onto the computer and search for themselves. We were concerned about whether they were going to get reliable information from a reputable web site," she says.

Sveningson helps patients navigate through the complexities of the health care system. She explains the treatment options and gives the patient the information that will help them choose the option that's best for them.

"A lot of it is knowing that what they are feeling is normal and that it's not unusual for people in their position to have problems sleeping or eating," she says.

Sveningson prepares the patients for the surgical consultation, educates them about what to expect from the appointment, and gathers the information a surgeon may need when seeing the patient.

She often accompanies the patients when they see the surgeon and follows up later to clarify any information they don't understand and

COMING IN FUTURE MONTHS

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answer questions. "We are available to be their second set of ears when they see the surgeon. Some people don't want us there, but we try to touch base and make sure the surgeon is aware of their story," Sveningson says.

Patients are encouraged to call

She encourages the patients to call her with questions and concerns, but she also calls them at regular intervals.

"Women are very overwhelmed by the diagnosis of breast cancer. We have this culture of stoicism that says you handle whatever is thrown your way. They won't always call and say they need help. When I call them, they appreciate it greatly," Sveningson adds.

A lot of patients are afraid to bother someone by calling with questions, or they may call and the surgeon isn't available to talk. The breast cancer case managers often can answer the questions, she adds.

Once the patient has had surgery, Sveningson starts preparing them regarding what to expect for their consultations to medical oncology and radiation oncology.

After patients receive a treatment plan, she follows up to help them understand the complexities of the cancer treatment.

"Patients often don't understand the treatment plan, and they are fearful of having chemotherapy and radiation. I'm able to re-emphasize how cancer is staged and how a treatment plan is determined. I give them the message that breast cancer can be cured," she adds.

Contact with the breast cancer case manager tapers off when the patients' postsurgical treatment begins.

"By the time they start chemotherapy, they have gotten through the major complexity of navigating the system and they need to be followed closely by medical oncology. At that point, most of their questions are related to their treatment," Sveningson reports.

Since the position was established, the health center has not received any complaints or negative feedback from breast cancer patients. A patient satisfaction survey showed high satisfaction with the program.

"We know that if one person has a negative experience or feels like they fell through the cracks that they are going to tell 10 people. We are here to make sure that doesn't happen," Sveningson says. ■

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. ■

Hospital Case Management
2003 Index