HOSPITAL CASE MANAGEMENT™

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

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Data help case management demonstrate its contributions

Information shows drop in avoidable days, concurrent review denials

While many case management organizations are struggling to demonstrate the contributions they make to patient care, reimbursement, and cost containment, the integrated case management department at Sarasota (FL) Memorial Hospital has overcome the barrier and can demonstrate with confidence how it contributes to organizational success.

"We use our data extensively within the department as well as outside the department. We are tuned into goals and focused on achieving results," says **Judy Milne**, RN, MSN, CPHQ, director of integrated case management and quality improvement at the 828-bed county hospital.

The department has an integrated model that includes financial case managers who are RNs and do all the insurance contacts; clinical case managers (RNs) who focus on medical necessity and utilization issues; psychosocial case managers who handle discharge planning and other social work-related interventions; and physician advisors. Teams of clinical and psychosocial case managers are assigned by unit and work from their assigned nursing unit geographically.

"This has worked well for us because the case management staff build a solid working relationship with the nurses on the floor and the physicians who usually use that floor. The medical staff know the case managers and know who to look for if they need something," Milne says.

The clinical case managers, financial case managers, and psychosocial case managers all make entries in the database system daily as a routine part of their work.

When patients are transferred from one hospital unit to another, having concurrent data at their fingertips helps the case management team that takes over the patients' care avoid duplicating medical necessity review or discharge planning activities that already have been done.

For instance, the patients may go from the intensive care unit or

telemetry unit to the medical-surgical unit. If the team on one unit has started the discharge planning process and documented it, the case management team on the receiving unit doesn't have to repeat tasks such as talking with the patient about being discharged to a nursing home.

The department focuses on discharge planning and utilization screening as well as ways to enhance efficiency and patient flow. It uses the data to demonstrate the impact of case management and to demonstrate that case management is a very intensive process.

"Our case management role is not substantially different from that described in a textbook. The real difference is that the staff are extremely engaged in achieving goals," Milne says.

Through the efforts of case management, the hospital has been able to lower its avoidable days rate from 45% to about 11%.

Sarasota Memorial was rated No. 1 in the country for Medicare efficiency by Milliman USA. "We have one of the best Medicare lengths of stay in the country, and we are 60% Medicare," she says.

By tracking the concurrent denial rates, the case management department has been able to show that it is overturning about 20% of concurrent denials and disagreeing with another 10% to 15%, flagging these for appeals.

Milne came to Sarasota Memorial Hospital in 1999, two years after the hospital hired Milliman & Robertson (M&R) of Seattle to redesign the case management structure.

There are about 50 full-time equivalent positions in Sarasota Memorial Hospital's integrated case management department.

"I knew when I got here that I was going to have to be able to defend a department this large by being able to show our impact. That's why the data are so clearly important," Milne says.

The hospital tracks its case management data using the Concurrent Care Management software sold by Eclipsys Systems and is one of the beta test sites for the new web-based version.

The care management software receives demographic and other stats from the hospital's main computer system, including admissions information, transfer information, and insurance and billing data.

As the case managers and discharge planners do their own data entry, the whole picture of the patient emerges, says **Greg Borden**, CURN, CCM, systems manager for ICM/QI/infection control. "We don't use all the fields in the program because we could easily turn our case managers into data-entry people. We minimize what we put in and maximize what we get out of it," he says.

Documentation begins in the emergency department (ED) and goes throughout the acute care setting, giving the hospital the ability to measure interventions and outcomes in all areas of care.

At Sarasota Memorial Hospital, senior management sets goals, which the case management department uses to establish its own goals and

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Editorial Questions

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define the activities that help them meet the goals.

For example, hospital management sets a goal of budgeted length of stay, an overall hospital aggregate, and tracks the overall length of stay for the hospital on a monthly basis.

The clinical case managers work on the discharge goals on a case-by-case basis, using M&R guidelines to determine the proposed best practices length of stay for the patient's diagnosis.

"We are really focused on proactive work, such as getting the patient type changed from 'observation' to 'inpatient,' or 'outpatient' to 'inpatient,' as appropriate. If you don't get it right, you can't bill for it," Milne says.

The database allows the department to track its impact on avoidable days and avoid denial of payment, as well as justify why certain things happen. If one unit's length of stay increases, the case management department can pull out data to show the reasons why. For example, patients with certain diagnoses may be ventilator-dependent or need wound care and have no post-acute option in the community; a particular physician may be resistant to discharge planning; or it may be difficult to find a skilled nursing facility to accept an unfunded patient.

"Our data include the kind of detail that gives us the confidence to answer many questions," Milne says.

Addressing avoidable days

The system is set up to track avoidable days and classify them according to whether they are related to physicians or the system.

"We can aggregate our data by reason and link it back to the DRG and the physician," Borden says.

System avoidable days include reasons such as no beds available in the post-acute unit, no wound care facility in the patient's community, delays in radiology and other procedures, or delays that occur because the cardiac catheterization lab isn't open on weekends.

For instance, using the software, the case management department was able to identify a cost of $1.7 million in avoidable days because the cardiac catheterization lab isn't open on weekends except during winter. However, a cost-benefit analysis showed that the cost of opening the lab on weekends exceeded the opportunity for savings.

"We're going to continue to track those days. Right now, we feels like it's not worth it from a financial perspective to add weekend services. The net dollar effect is that there would be no significant gain, and the patient outcomes haven't suffered," Milne adds.

"Physician avoidable days" occur when the physician isn't taking the necessary steps to progress the patient's care and recovery or has failed to write a discharge order.

"The chart may not sufficiently represent what is going on with the patient. That's why the case managers work with the doctors," Milne says. "If the chart doesn't look like the patient meets the criteria for continuing to stay in the hospital, the case managers find out what else might be going on and prompt the physician to put it in the progress notes."

If a case manager is working with a patient who did not meet criteria for continuing to stay in the hospital, he or she talks to the physician, then goes into the computer system and places a referral for a physician advisor on a potentially avoidable day.

Based on the review, the physician advisor talks to the attending physician. The result of that discussion is either action by the physician involved or an avoidable day. The case manager documents the final outcome in the system based on physician advisor feedback.

"When we look at avoidable days, we can identify them by category and determine if there is an area of opportunity from an operational standpoint or look at diagnoses that seem to be problematic or physicians that have more avoidable days than their peers," Milne says.

The system gives the hospital the ability to break out avoidable days by physician and tally the cost of the avoidable days.

The hospital sends reports to each physician who had more than six physician-related avoidable days in a quarter, giving specific information, including the costs.

"When we did this the first time two years ago, we sent out 75 reports. Recently, we sent out just 10. We can see our system is working because we now have more compliance on the physician end," Borden says.

The financial case managers use the system to track concurrent denials when an on-site reviewer denies payment. The system generates a daily list on patients being concurrently denied.

"What we are trying to do is to resolve the denial before the patient is discharged. We try to take care of whatever we can before the patient leaves. You save money in the long run if you can

fix it before it goes into the retro billing system," Borden says.

The case managers document when they get the denial overturned, when they agree with the denial, or when they disagree with the denial but were unable to get it overturned.

"We can show the value of the department by showing that we're getting 20% of the concurrent denials overturned," Borden adds.

Three months later, when the denial letter comes from the payer, all of the information needed for the appeal is already in the system.

One advantage is that no one has to assemble information for the appeal long after the patient has been discharged. Another is that the hospital doesn't waste its resources in appeals it is likely to lose. "If the case manager agreed with the denial, we don't appeal it. We depend on their clinical expertise," he explains.

The hospital tracks retrospective reviews in the same way. Potential error due to status, such as observation or inpatient status, is another area of concern. "We try to catch them on the front end. We are constantly looking for it so we can get it changed to the appropriate status," Borden says.

"We can document how many we had per quarter and how much we saved by catching them. We can also generate reports showing the reason for the denial, whether it was a physician or a particular unit," he adds. ■

Discharge planning system makes documenting easy

Tracking which patients go to which facilities

At Sarasota (FL) Memorial Hospital, discharge planners don't spend a lot of time checking off boxes to document each individual task they have performed.

"Discharge planning is something that is not measured well because the case managers, psychosocial case managers, and social workers do so many things at once," says **Greg Borden**, CURN, CCM, systems manager of ICM/QI/infection control.

To make discharge planning documentation easier, the hospital's integrated case management department has created a discharge classification "value system" that rates patients by complexity of discharge on a scale of 1 to 5.

As staff enter the disposition and intervention codes, the system rates the complexity. For the most part, staff do not know what the complexity of a particular patient will be.

The system was designed to do the calculation and take the emotional aspect of deciding how complex the discharge planning was out of the equation, Borden says.

"We took the tick-mark mentality out of it. The discharge planners don't have to mark down everything they do. We know the major highlights of what they do, and we have put a value to it," he says.

Sarasota Memorial Hospital discharge planners handle between 1,500 to 2,000 cases per month, making it almost impossible to document every little task they do on a daily basis.

When case managers have to document by checking off boxes, they often get several days behind and have to go back and fill in, sometimes forgetting what they actually did, Borden says.

"If a patient is going to a skilled facility, we know that the discharge planner needs to talk to the family and make calls to set up the transfer. They don't need to document that in the tracking system because it happens every time," he adds.

To create the value system, the hospital designated five levels of discharges, ranging from Level 1, a simple discharge that takes about half an hour, to Level 5, a catastrophically ill patient whose discharge activities take about eight hours on average.

"The specific detailed information goes into the electronic chart. What we want to know is the complexity of the patient and what it took for discharge. We try to minimize any duplication between the chart and the tracking system," says Borden.

The system allows the department to calculate the full-time equivalents or workload and show the number of hours used in discharge planning.

In addition to quantifying the discharge planning work, the information is useful in staffing each unit, he adds.

For instance, orthopedics has a high volume, but most of the patients are low-level patients, hospitalized for planned surgery, who have everything in place before the surgery. Other units may discharge a low volume of patients who have very intensive needs, he says.

The hospital monitors the disposition of patients and takes it a step further, setting up codes to specify which home health agency, skilled facility, or rehab facility received the patient, allowing the

department to track which facilities are taking which kind of patients.

"We can run reports to know which agency gets the bulk of the discharges. We know who is getting all the gravy and who helps the unfunded patients," says **Judy Milne**, RN, MSN, CPHQ, director of integrated case management and quality improvement.

The case managers have found the information useful when placing patients.

The hospital uses the information internally for its own skilled nursing facility, rehabilitation facility, and home health agency.

"It has helped them internally see where the marketing opportunities are. They always knew how many patients they got. Now they know how many go elsewhere," Borden says. ■

Inpatient case managers handle discharges, review

Hospital shifts from reactive to proactive focus

When **Jeanne Musolf**, MS, RN, CCM, talks with new employees about the inpatient case management program at Children's Hospital of Wisconsin, she often tells them, "expect that how things are currently will not be how they are six months from now. We're always trying to improve and change."

Since Musolf assumed the role of manager of care coordination services at the Milwaukee facility in April 2001, the department has undergone a comprehensive redesign. At that time, there was a small staff of discharge planners and a separate utilization management department that did concurrent/retroactive reviews and denials.

"The discharge planners practiced in a reactive mode. They responded to orders for home health care or durable medical equipment [DME] as the beginning point for the discharge planning process," she says.

The inpatient case management department took over concurrent utilization review in June 2001. At the same time, discharge planning became more proactive via a unit-based model.

"We went from being a reactive discharge planning department that waited for referrals to come to us to being a proactive case management department," Musolf says.

The hospital now is in the process of shifting all utilization functions to the inpatient case management department. The department now handles concurrent reviews, but retroactive reviews and denials will be added soon.

Department staff were increased so that now a case manager is assigned to each unit in the hospital to handle discharge planning and concurrent review. "We adopted the unit model rather than a population-based model because there are so many children who don't fit into a particular population. If we assign them by diagnosis, we could have some children who fall through the cracks," Musolf says.

Each nursing unit runs from 24 to 36 beds, except for peak census times in the winter months, when many children are hospitalized for respiratory disorders and the census on some units can climb to 40 or more.

The department has 8.8 full- and part-time employees who cover seven units, including the general medical unit, neonatal intensive care unit, pediatric intensive care unit, surgery/rehabilitation floor, oncology/transplant, intermediate intensive care unit, and a unit that cares for children from birth to 18 months old. Included in that number is the supervisor of the department, **Jennifer Friess**, RN, CCM.

"The inpatient case managers on each unit have become real experts in coordinating the care for children with those particular diagnoses and issues," she says.

The case manager assigned to a unit reviews the needs of the patients and the payer requests for information first thing in the morning, and then starts the process," Musolf says.

The inpatient case managers at Children's Hospital of Wisconsin work with all children on their unit but typically spend a great deal of time with the children who have very complex medical needs. Many children go home with gastrostomy tubes/feedings, intravenous medications, and/or on ventilators. Their families need to take care of a chronically ill, medically complex child day in and day out. Complicating the situation is that sometimes the family also has complex psychosocial issues, Musolf says.

Medically complex children must be cared for in their homes or in a foster home because there are no special facilities for them in Wisconsin, she says.

"There are a lot of differences in the pediatric and adult world. With adults, case managers have clinical pathways and disease management programs as resources. We deal with many children

who always will be a variance on a pathway," says Musolf.

Handling discharge needs for complex patients who are in the hospital a short time presents a challenge to case managers.

The case managers who work with children in the neonatal intensive care unit, the intermediate intensive care unit, or the oncology unit may have a week or more to assist in transitioning the young patients back to the community. These children require more intensive discharge planning interventions than a child who is in and out of the hospital very quickly, she says.

One of the biggest obstacles to discharge planning for medically complex children is finding a private duty nurse to help with the child's needs at home, she adds.

"The nursing shortage in the community makes it really difficult to set the kids up with private duty nurses," Musolf says.

Recently, the hospital created a web site for private-duty nurses. These are independent nurse providers who bill directly to Wisconsin Medicaid. The web site offers a way for the hospital to inform the nurses about children who need care, and for the nurses to let the hospital know when they are available.

The inpatient case managers take turns being on call for the hospital's ambulatory clinics. The case manager on call is paged when an issue arises in the clinics, such as a patient needing home nursing care or DME.

The hospital's peak census occurs each year from mid-January to mid-April when children tend to have more respiratory infections, making it necessary to add staff on a temporary basis. During peak census, all hospital staff, including the inpatient case managers, sign up to work more hours to accommodate the needs of all the children hospitalized. Children's Hospital of Wisconsin has had a proactive plan in place for the past five years.

The inpatient case management department has put together a peak census plan that requires part-time people to work extra shifts when a full-time person has a day off or when they are available to be an "extra" (due to high census and demand) during the week. Full-time staff are asked to be on call as a second inpatient case manager on Saturdays.

Musolf has high praise for her case management staff, who always are willing to fill in when needed. "Our staff are unbelievably dedicated. They work as a team. We've all had a lot of personal family issues with sick parents or children, and everybody is always willing to come in when they're needed," she says.

Inpatient case managers rotate covering the weekends. The unit case managers leave messages alerting the weekend case manager of what may need to be done for their patients.

"The inpatient case manager covering the weekend sees the new patients and those who are being discharged. It can be a busy job," says Musolf.

The department also has employees who are designated as float staff and casual staff. The float staff are part-timers who fill in when regular case managers are scheduled off, working weekends, on vacation, or to cover illness. The casual staff are nurses who help out when there is extra utilization management work that needs to be accomplished.

"My vision is to create a case manager associate role, similar to a nursing assistant role. These staff members would team up with the case managers and take on the more technical tasks, such as ordering nebulizers, verifying benefits, or performing simple utilization management activities. That would free up the nurse case manager to become more involved in care coordination," she says.

While the unit caseloads are higher than Musolf would like, she and Friess are working to come up with ways to assure that the role of the inpatient care manager evolves to best accomplish the goals of the children and families who need their services.

"For this kind of model, when case managers perform discharge planning and utilization management, a unit with approximately 20 beds would be ideal," she says.

The department continually is looking at ways to improve the role of the inpatient case manager, keeping in mind the needs of the family, the health care team, and the payers, Friess points out.

"The three components of the role: Care coordination, discharge planning, and utilization management is what the inpatient case manager role consists of and is what the staff strive for," she explains.

"We have a wonderful team of inpatient case managers who have been put to the challenge. They have done a great job on each of their units introducing the role of the inpatient case manager and becoming an integral part of the health care team," Friess adds. ■

CRITICAL PATH NETWORK™

SSM slashes LOS almost two days in just two weeks

'Consistence, insistence, and persistence' are keys to success

Reducing patient length of stay (LOS) from nearly seven days to the regional average of 5.5 days usually takes two years, according to the Health Care Advisory Board, a nationally recognized organization that provides best practices research and analysis to the health care industry.

But SSM St. Mary's Health Center in St. Louis, a 582-bed community teaching hospital, did it in just two weeks. And while achieving a high level of patient satisfaction, it further reduced its LOS to five days 30 days later — ultimately reaching a record low of 4.7 days by the end of June 2002.

SSM St. Mary's Health Center is a member of SSM Health Care, which was named winner of the 2003 Malcolm Baldrige National Quality Award — the first ever presented to a health care organization.

The keys to success for SSM were "consistence, insistence, and persistence," says **Mary Overstreet**, RN, BSN, director of case management.

"We communicate with you; we talk about what needs to happen with the patients in order to have effective quality care — which will automatically improve LOS," she explains.

"We do not go away. Every physician hears the same message, every day of the week. We are insistent, and we will have the literature and best practices to back up what we say. There are no sacred cows. And this is not just a flavor-of-the-month change; this *is* our new process."

In addition, Overstreet and her staff promoted case management as a service to the physicians and their patients, as opposed to a punitive component of admitting.

"We want you to see us as a service the hospital is providing for you, because if you wanted your own case manager, it would cost you a fortune," she explains. "We'll figure out why your 'echo' is not being done in a timely manner, track it down for you, and be your eyes and ears when you are not at the hospital."

How it started

The process began on April 17, 2002. The Medicare LOS for SSM St. Mary's Health Center was 6.8 days for the month. The health center was struggling with inflated costs and poor patient flow. Hospital president **Ken Lukhard**, agreed with his supervisor, Mike Graue, executive vice president of network operations for SSM St. Louis, that changing the hospital culture was necessary to reduce LOS, and that it needed to be a CEO-driven effort.

Not wasting any time, Lukhard called on Overstreet to pull together a plan for getting at the root cause of the problem. He asked her to offer suggestions on how to improve; he gave her two hours to prepare a presentation.

Overstreet, with the help of Alka Kapoor, a physician advisor to case management, redesigned the CM model. They presented the new model to Lukhard that afternoon.

Afterward, Lukhard called an emergency meeting of the medical executive committee. He received their full support for the new model, and it was implemented the next day.

"We went through a lot of the CM literature out there," Overstreet recalls. "One of the sources we primarily used was by Kathleen Russell-Babin, *Scaling the Outlier Brick Wall* (Center for Case Management; 1999). It not only looks at

what keeps patients in the hospital, but at your own processes that are not functioning properly, which can also keep them in longer."

Internally, two teams were formed. The short-stay action team consisted of Lukhard, Kapoor, Overstreet, and others, including the social work team leader, Senior Care Coordination Center physician and director, case managers and social workers, and a representative from rehabilitation.

The long-stay action team included representatives from the same groups plus medical staff representing various specialties (department medical directors).

Both teams met daily for an hour discussing LOS triggers within their respective length of stay time frames. The short-stay team focused on cases with LOS of three to four days that appeared ready for discharge but had no documented discharge plan.

The long-stay team focused on patients with an LOS of more than 10 days. Once triggers or processes that caused an increase in length of stay were identified, they were re-examined and addressed, Overstreet explains.

Some easy fixes

Many times, team members discovered an oversight that could be fixed easily. For instance, it was learned that some short-stay discharges were delayed pending a cardiologist's reading of an echocardiogram. Once a daily schedule was established for a cardiologist to read echocardiograms of patients to be released, the LOS was reduced.

"The first triggers we identified addressed patients in the hospital for more than 10 days," Overstreet recalls. "We would take each case and look at it and say, 'If you were medically ready to be discharged today, what are the impediments? If you are not medically ready, what can we communicate to your physician to make sure you get the best care possible?'"

Overstreet was put in charge of implementing the plan, with the full support of administration. Additionally, the physicians were kept well informed and involved throughout the entire implementation process. "Our administration constantly involved the physicians. This was very important," Overstreet says.

She explains that Lukhard often visited the physicians lounge to ask how the medical center could improve operations. Plus, he sent mailings to physicians' homes to keep them in the loop. Overstreet says she is looking forward to a third physician survey to be conducted soon, having already seen the physician approval rating increase from 54% to 80%.

The implementation of the new CM model involved breaking down a lot of barriers, notes Overstreet. "There were poor processes, and a lot of the culture needed to be changed," she notes. "In particular, we had to address communication horizontally and vertically."

For example, she says, many staff were reluctant to approach physicians for fear of bothering them. When asked why, the reply often was something like, "No one ever has for 10 years."

"Our response was, 'Well, let's start," says Overstreet. "We took a fresh look at everything."

Results are retained

Not only were the initial results impressive, but St. Mary's has kept those gains. The hospital has kept its LOS low for well over a year. Other major benefits also emerged. Emergency department (ED) diversion fell from more than 200 hours per month to less than 75 hours; the health center's operating margin improved $1 million in 30 days; the readmission rate remained consistent; and most importantly, patient satisfaction — as well as physician satisfaction — did not decline.

From the point of implementation of the new CM model to significantly reducing LOS, Overstreet has kept a notebook of the plan, the activities, the progress, and the outcomes of their remarkable journey that illustrates the power of teamwork.

Could St. Mary's success be modeled by other facilities? Overstreet says yes. "The first thing you need would be CEO support — it's by far No. 1," she asserts. "Our hospital president became intimately involved; he had case management report directly to him and met with me twice a week."

In fact, she says, people made jokes about her trying to teach him medicine. "But when he talked to the docs, he could sort of talk their language," she observes.

The other key factor, she says, is consistency. "This cannot just be implemented for a short period of time," she insists. "What we're really promoting is quality — not just a decrease in length of stay to save money. If you market an initiative as an effort to effectively improve quality, by its very nature it will reduce LOS."

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Computer documentation won't cure all problems

Make good use of available technology

For years, health care managers have been reworking documentation forms trying to streamline the process to make it fast and efficient to increase compliance. No one ever designed the perfect form.

Now that technology quickly is making pen-and-paper charting obsolete, will the conversion to on-line documentation be just as difficult to perfect?

Although only a fraction of health care facilities currently document on-line, those that have installed computerized charting do find that they reap many benefits.

When **Jennifer Robinson**, RN, MHS, patient education coordinator at Roper St. Francis Healthcare in Charleston, SC, queried various disciplines for comments about on-line documentation, no one had anything bad to say about the health care facility's system, which was implemented in 2002.

The benefits mentioned include:

- It helps staff focus on the important elements of teaching when they are busy so they don't leave anything out.
- Gaining access to the documentation form is quicker and much more timely on-line because there is no waiting for a chart. Several disciplines can chart on the same patient at the same time via a computer.
- You can document or review documentation from any location, including the office, so it is easier to review what has been taught by other disciplines.
- Documentation is more legible and communication is improved because there is one uniform place to see where everyone has documented.
- The progression of patient education from day to day is more easily visible because those reviewing it can scroll back to the day before.
- It is user-friendly because staff just point and click to document and then type a few words for further detail.

However, just because documentation is computerized doesn't mean that staff will embrace it. Computer technology must be used fully, and systems need to fit the user and their needs.

When the on-line documentation system for patient education was designed at New York-Presbyterian Hospital in New York City, the goal was to create the familiarity of the paper form that staff had become accustomed to while making full use of technology.

It usually is not efficient to transfer the paper form to the electronic system, says **Virginia Forbes**, MSN, RN, program director of patient and family education. "You can design it so you have some familiarity of look and the content that is required by regulatory agencies and your own needs, but still make it more efficient to use," she says. Efficiency comes with incorporating such computer technology as drop-down menus and links to protocols or resources.

To document, staff log onto the flow sheet section and bring up the patient education documentation on the screen.

Much of the documentation can be completed from drop-down menus; however, the option of entering text also is available. drop-down menus are used to document the learner, the topic taught, the method of teaching, the evaluation of teaching, and barriers to learning. These sections are mandatory, and there is an automatic sign-off when they are completed.

For example, to document the method of teaching, the educator could select from a drop-down menu with several teaching methods such as a one-to-one session or using a video or CD. Once this is documented, the next mandatory screen is the evaluation of learning.

When converting a paper form to the screen format, it is important to be open-minded and not force an exact duplicate, says **Karen Guthrie**, RN, MS, coordinator of patient education at Mount Carmel East in Columbus, OH.

The paper form at Mount Carmel East had a lot of sections for writing text, while the computerized documentation has a lot of point and click. For example, educational topics are listed in alphabetical categories, such as topic E-L and M-P. When a user clicks on the A-D section of topics, he or she would find topics such as angioplasty, blood transfusion, chemotherapy, and dressing change.

There's also a screen for teaching methods —

demonstration and outcomes, such as "performed independently" or "needs reinforcement."

While lists are convenient, it is important not to make them too complex or tedious, Guthrie says. "We learned this by experience." In the past, designers went overboard on selections, providing way too many choices. She suggests including the most frequently selected categories and allowing space for text so that disciplines can provide written comment.

A close match of the paper form and computerized system can work if the form is designed with the conversion to on-line documentation in mind, Robinson says.

Staff were receptive to changes

The team designing the computerized documentation of patient education at Roper St. Francis Healthcare knew it would be well received by staff because a multidiscipline team had streamlined the paper form so that it easily could be converted to a paper version.

"The staff were very receptive to it because they were already familiar with it, and we had already had a lot of success with the paper version," Robinson reports.

However, the system does not always work perfectly from the start. Therefore, feedback from staff helps with improvements. The documentation of patient education was added to Mount Carmel East's computerized charting system two years ago upon staff request. Staff members said it would be easier to document patient education on-line because they already were on the computer for other charting.

Each discipline has screens for charting, and patient education documentation is included in these specific sections. However, the information entered is transferred to a common screen that all disciplines have access to so that they can review teaching in its entirety.

Another improvement to the system that was made after its implementation was the addition of separate documentation screens for diabetes and heart failure. The diabetes educators said they would like more detail for diabetes teaching documentation, as did disciplines that work with patients who have heart disease.

At New York-Presbyterian Hospital, a link to teaching protocols was added when staff said that it would be easier if they could go to a source that provided information on what to teach for a particular health issue, such as managing acute pain. If a staff member is teaching on any one of 20 topics for which there are protocols, he or she can pull up that resource on the computer.

Determining if people actually are documenting patient education and where compliance is lax certainly is easier when the process is on-line, says Robinson. Instead of having to manually pull 10 charts to review documentation, those monitoring compliance can check charts from the computer moving from one patient to the next in a quick and efficient manner.

Currently, each interdisciplinary department monitors the documentation of patient education at Roper St. Francis Healthcare giving its information to Robinson, who converts it to graph form so it can review its compliance over the years. The latest results were 97% compliance on documentation, but Robinson attributes the high numbers to the fact that each department monitors its own compliance.

Before on-line documentation was implemented, compliance was high because departments are consistently focused on documentation through the monitoring process, she says.

Yet other facilities have seen an improvement in documentation by moving the process from pen and paper to the computer. Compliance increased by 30% at the campuses within Forbes' health care system that have on-line documentation. While there are many reasons why compliance might improve, she says that the simplicity of on-line documentation makes it much more likely that staff will comply.

However, on-line documentation has not improved physician compliance. "Although all clinical disciplines are expected to document, we have a low compliance with physician entries," says Forbes. In the upgrade of the system that currently is taking place, a component on patient teaching is being added to the physician entry section. These entries automatically would cross over to a general patient education documentation section for the patient that all disciplines easily could access.

Although on-line documentation may not solve all problems associated with noncompliance, most patient education managers agree that the conversion has been greatly beneficial.

"We always had a difficult time deciding where to keep our care plan and patient education record, whether at the bedside or in the chart. Now, no matter what unit you are working on, you can easily get to the patient education documentation screen," Guthrie adds. ■

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Do you offer a choice on home care services?

It's the law, but no one's looking yet

Discharge planners at some facilities apparently are either unaware of — or are ignoring — a federal requirement that hospitals offer patients a choice of home care providers and that they tell patients when there is a financial interest between the hospital and an agency to which the patient is being referred.

Despite clear provisions to that effect under the Balanced Budget Act (BBA) of 1997, several sources tell *Discharge Planning Advisor* that they are aware of hospitals that routinely refer patients to an affiliated home health agency for care, without either mentioning the other providers that are available or disclosing the connection between agency and hospital.

At the other end of the spectrum are hospitals that have a clear, proactive policy in place for ensuring that patients are aware of their home care options.

The good news for noncompliant hospitals is that repercussions aren't likely to be felt until at least sometime next year, which looks to be the soonest that any type of monitoring process could be in place.

"We had so many provisions [of BBA] to implement that it's taken a long time catching up with all of them," a spokesman from the Centers for Medicare & Medicaid Services (CMS) tells *DPA.* No further action has been taken following the publication of a proposed rule in the Nov. 22, 2002, *Federal Register*, he says. The comment period ended Jan. 21, 2003.

"A draft version of the final regulation is in the clearance process here," the spokesman adds, but he says the rule then will have to be cleared by the Department of Health and Human Services (HHS) and the Office of Management and Budget (OMB). It's not uncommon for just the OMB piece of the process to take 90 days, he explains.

The interest and concerns expressed by the home care industry in CMS's "Open Door Forums" provided the impetus for the rule-making process, the spokesman adds.

Once the rule is in place, he said, hospitals will be required to begin submitting data on their post-acute care referrals and will be monitored on their actions.

That day can't come soon enough for **Ann Bender**, MHA, RNC, CMC, owner, president, and CEO of Private Care Resources Inc. in Duncansville, PA. "[Discharge planners] need to realize there is a requirement there to offer options to the patient," she says.

Bender, whose company provides home care services, says she experienced the situation first-hand when her mother was hospitalized in 2002.

First, Bender says, she had to cancel arrangements that had been made to have home health care provided by the hospital-affiliated agency. Then, when she arrived to pick up her mother, she learned the equipment needed had been ordered from the durable medical equipment (DME) company connected with the hospital.

"I said, 'Who made the choice?' and the nurse said, 'We thought it would be convenient.'"

When the nurse didn't seem to understand the reason for her concern, Bender says, she decided to handle the matter after getting her mother home. "I called the DME company and said, 'Come get your stuff,' and then I called the company I wanted."

Section 4321 of the BBA, *Nondiscrimination in Post-Hospital Referral to Home Health Agencies and Other Entities,* paragraph (a), *Notification of Availability of Home Health Agencies and Other Entities as Part of Discharge Planning Process,* has four requirements:

1. Hospital staff must provide patients referred for home health with a list of agencies available

in the area where patients reside (Pub. No.105-33, Sec. 4321, 111 Stat. 394, 1997).
2. Agencies must formally request each hospital to list them as available for service delivery.
3. Hospitals may not specify or otherwise limit qualified agency providers.
4. Hospitals must tell a patient when there is a financial interest between the hospital and agency if the patient is referred to that agency.

In the case of the hospital she dealt with, says Bender, "I'm sure [the nurses handling the discharge] are not aware [of the federal requirement]. Their directive is, 'You refer to our own.'"

Patients leaving the hospital, meanwhile, often are not in the best frame of mind to take a proactive approach in arranging their care, she says, and may say something like, "Who do you think I should use? Just set it up."

In contrast to the hospital Bender describes, discharge planners at Mt. Ascutney Hospital and Health Center in Windsor, VT — and throughout that state — with the best intentions of following the BBA directive find themselves facing an unusual challenge.

The state of Vermont requires all home care services to be offered through local Visiting Nurse Agencies (VNA), with the aim of providing quality care to all levels of need, regardless of insurance status, explains **Cheryl Briere**, RN, CCM, director of case management at Mt. Ascutney. As a result, there is no choice for patients who require home care services.

"Every state may have different regulations" concerning home care, she points out.

Neighboring New Hampshire, where Briere worked for most of the past 10 years, "is totally different," she adds. "It allows for-profit nurse staffing agencies to compete with the VNA, giving patients several choices for home care services."

The particular difficulty Vermont discharge planners face, Briere says, stems from two things: "The patients being discharged are more complex than ever before, and due to staffing shortages, the VNA often is unable to offer as much care as might be requested."

As part of a quality improvement process, she adds, Mt. Ascutney case managers have been making follow-up telephone calls to patients within a few days of discharge to determine if home care services have been initiated.

"We have cases in which the patient does not receive services within the appropriate time," Briere notes. "If we order physical therapy three times a week, we get it two times a week."

Her department is wrapping up six months of data collection, she says, and will sit down with VNA representatives to identify problem areas and possible solutions.

Further complicating care delivery, she says, is the rural nature of the state. "It often takes two hours to get to somebody's house.

"If care is not available, and if there is no choice," Briere adds, "how do you advocate for the patient for the appropriate level of care?"

As for other post-acute services — such as intravenous infusion and chemotherapy or total parental nutrition — Mt. Ascutney case managers are able to offer some choice to patients, she says, although nursing services associated with these therapies still must be delivered by the local VNA.

"We say, 'Here are your choices,'" she notes, "and if the patient doesn't have a preference, we can offer suggestions, can say, 'We had great success with this company,' because there are those that provide better service for a particular item and still meet the criteria for patient choice."

To ensure its compliance with the BBA regulation, Briere says, Mt. Ascutney already has implemented a policy and procedure for post-acute care referrals. Patients are given a list of available vendors from which to select and are asked to sign a document saying they've been given that choice, she adds.

A small, rural "critical access" hospital with a rehabilitation unit as well as acute care beds, Mt. Ascutney finds itself on the other side of the referral equation, Briere points out, when an area hospital refers patients to its rehab unit.

"As a critical access hospital, we're allowed to have a total of 25 beds and no more than 15 acute care beds, so we can bring in rehab patients to fill in the difference," she explains. Because of the hospital's space constraints, Briere says, sometimes there is a backlog of referrals.

That puts her in the position of reminding the referring hospital's staff of the need to offer patients other rehab choices or, if appropriate, home care, she notes.

At OSF Saint Anthony Medical Center in Rockford, IL, discharge planners offer the full range of post-acute care options to patients, explains **Joyce Nicklas,** RN, MBA, director of quality/care management.

"When staff go in to interview patients [regarding post-discharge care], we just give them the names of all we're aware of," Nicklas says. "We let them know there's a choice, and ask

them if there is an area — like a mileage range — that would be their first choice. Then we give them the list of agencies that are in that radius."

The home care agencies are in alphabetical order, she notes, which means the hospital-affiliated agency, the name of which begins with "OSF," is far down the list. "We tell them up front it is affiliated with the hospital but that they have no obligation to use it."

To keep the process objective, Nicklas says, patients are asked what they are looking for in a home care provider, and are encouraged to check agency web sites and rankings given by the *Chicago Sun-Times* and other entities. "We also tell them to talk to their physician, so we're not imposing [our views]," she adds.

The process is so evenhanded, Nicklas says, that the affiliated agency — far from having the majority of hospital referrals — gives the feedback that it isn't receiving very many patients from that source.

When hospitals fail to abide by the BBA rules, she suggests, it may have to do with the discipline that is handling the process, as well as with a lack of training.

Social workers — who coordinate referrals at Saint Anthony's — tend to be more in tune with such directives than are nurses, Nicklas notes.

"At some hospitals, what they call case management — and the training that goes into it — is so varied," she points out. "A general staff nurse or someone who has not worked on the case management side of things may not be aware that [the BBA directive] is out there." ■

Hospitals seeking SNF beds think creatively

Early discharge planning called crucial

As hospital discharge planners and case managers struggle to place patients with complex care needs in skilled nursing facility (SNF) beds amidst the challenges of the prospective payment system (PPS), many are keeping their heads above water with a mix of timely planning, community collaboration, and creative thinking.

That's the combination recommended by **Pat Orchard**, CCM, CHE, RN, MSHA, MEd, market development executive for a Philadelphia-based consulting company called Care Science. "When hospitals call, I tend to be the person who does the assessment of what's going on in terms of discharge planning and case management."

As a former nursing home administrator, she sees both sides of the problem: Hospitals must find places for increasing numbers of stable but medically complex patients. Nursing homes can't afford to keep their doors open if their patient mix is too heavily weighted toward these high-cost patients.

A big part of the dilemma is that nursing homes can say no, Orchard notes. "They can say, 'Sorry, I can't take that patient.' It's not like a hospital, where they have to take them."

New pharmaceuticals and advanced technology are adding to the logjam created by the PPS, Orchard points out. "There are expensive drugs the nursing homes can't possibly maintain with their reimbursement and equipment needs that are more expensive than they used to be."

If care requires an advanced bed system — for a burn victim, for a frail, elderly person, or for an obese patient — "most nursing homes don't keep those, and they have to be bought or rented," she says. "You can [afford to] put those in an acute setting, but in a nursing home setting it may be cost-prohibitive."

Community collaboration is crucial in such instances, Orchard notes, and often includes a healthy measure of negotiation and relationship-building. Ideally, she says, nursing homes will agree to take higher-cost patients if they get a fair share of the less complex variety.

Sometimes, she adds, hospitals — and payers — find ways to make it easier for the nursing home to cover the cost of a complex patient. "There are patients who need IV antibiotics long-term, and they are expensive. Many payers offer to work with the nursing home to continue to provide those through additional reimbursement above the daily rate."

In the Medicare realm, "the leeway is limited. It frequently depends on what the antibiotic is, but a physician who is more in tune [with financial concerns] may transition more quickly to another [less expensive] kind of antibiotic," notes Orchard.

In some cases, she adds, hospitals may send the necessary equipment to the nursing home along with the patient.

Those kinds of solutions require that a discharge plan be created as early as possible, Orchard emphasizes.

"The sooner the plan is put together and you

can discuss it, the quicker you can start resolving some of the issues," she says. "You may want to do some joint responsibilities. The providing facility may work with the sending facility to cover some of the expenses.

"For example," she adds, "the hospital may rent some equipment and keep sending it over [to the SNF] until the patient doesn't need it anymore." Or, Orchard says, as mentioned above, the hospital can collaborate with the physician and the nursing facility on covering the cost of antibiotics and other expensive medications.

"Many of the commercial payers work with the nursing home and providers to add more dollars," she says. A win-win situation can be created, Orchard notes, because the patient's benefits are not used up as quickly. "The physician makes sure the patient gets the services needed while moving the patient to a lower level of care, which is beneficial for everybody.

"There is some flexibility," she adds, "but it needs to be well-planned out and orchestrated with all parties. You can't do it on the day the patient is discharged."

That's the kind of cooperative approach taken at OSF Saint Anthony Medical Center in Rockford, IL, explains **Joyce Nicklas**, RN, MBA, director of quality/care management.

She notes that the problem in finding enough SNF beds is not so much the number of beds as it is the payer mix required by the nursing facility. "They're looking at how many more Medicare and Medicaid patients they can take. There might be beds out there, but because of their financial situation, they're not able to take all comers. So they stratify to get some kind of balance."

To facilitate patient placement, Nicklas says, she meets every other month with SNF administrators, as well as with representatives from hospices and other nursing homes. "We're just trying to work on some kind of collaboration," she adds, "[letting them know] we're not trying to get rid of patients, or you're being dumped on, but that there are a lot of common performance indicators, and how do we manage those collectively?"

To ensure care consistency, for example, the hospital and nursing home share forms containing information on patient treatment, Nicklas says. "If the patient is on a skin protocol [at the SNF], we bring that here with us. If they're doing a good job, we want to be able to keep that up."

"Then, we give [SNF personnel] a contact person here, so they understand what we teach our patients at discharge," she adds. "If the patient starts to deteriorate [back at the SNF], they have someone to call, to do some troubleshooting, so the patient is not sent directly back to the hospital."

Thanks to case management initiatives in the emergency department (ED), Nicklas says, SNF patients who are brought to the ED because their blood pressure dropped or their condition began to deteriorate — and in the past would have been admitted to the hospital — often can be treated and sent right back to the nursing facility.

"They might just need an IV dose of antibiotics and to get started on therapies," she notes. "Some are identified as needing palliative care and there's nothing we can do for them here. We have Social Services go down and talk to the family, and they are sent back." ■

CE *questions*

1. The integrated case management department at Sarasota (FL) Memorial Hospital includes which of the following types of case managers?
   A. clinical case managers
   B. financial case managers
   C. psychosocial case managers
   D. all of the above
2. To make discharge planning documentation easier, Sarasota Memorial Hospital's integrated case management has created a discharge classification value system that rates patients by what?
   A. number of comorbid conditions
   B. amount of caregiver support
   C. complexity of discharge
   D. none of the above
3. Milwaukee-based Children's Hospital of Wisconsin opted for what type of model design?
   A. population-based
   B. physician-based
   C. task-based
   D. unit-based
4. The long-stay action team at SSM St. Mary's Health Center in St. Louis focused on what group of patients?
   A. all ventilator patients
   B. patients with a length of stay of more than five days
   C. patients with a length of stay of more than seven days
   D. patients with a length of stay or more than 10 days

Answer Key: 1. D; 2. C; 3. D; 4. D

GUEST COLUMN

Navigating the 'Bermuda Triangle' of ethics

Strategies for hospital case managers

By **Toni G. Cesta**, PhD, FN, FAAN
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Hospital case managers routinely face what I call the Bermuda Triangle of case management ethics. The top of the triangle is the clinical concern, encompassing the medical and treatment needs of the patient. On the right are the financial concerns, and on the left are the legal and ethical issues. In the middle of this triangle is the patient.

For the case manager, navigating this Bermuda Triangle is challenging, given the complexity of the issues and the ramifications that a decision in one area has on the other two.

The best course of action is to fully understand the issues involved, to identify the ethical dilemmas, and to seek the advice of supervisors or hospital administration.

To further this understanding, let's consider each point of the triangle. Starting at the top, the clinical concerns relate directly to the needs of the patients that come into the acute-care setting. As care is rendered, one of the considerations is the length of the hospital stay, which will require a review to be given to the insurance or managed care company.

This brings us next to the financial point of the triangle. The hospital case manager must balance hospital resources and the length of stay with the needs of the patient. For example, let's say the targeted length of stay for a pneumonia patient is four days. The goal would be to optimize those four days so that treatment will progress according to plan.

What happens, however, if on the fourth day the patient is not moving along as expected toward the desired outcome? Perhaps there's a medical complication or a clinical setback. The insurance company recommends the patient be discharged and that intravenous antibiotic treatment be continued at home.

The hospital case manager, however, is concerned that the patient lives alone and may not be able to manage his or her own care cognitively or physically at home, even with a visiting nurse. After concerns are discussed with the insurance company, the recommendation still is to move the patient to home-based care.

This dilemma puts the hospital case manager at the third leg of the triangle, facing legal and ethical issues. The case manager does not believe it is appropriate to discharge the patient. Yet keeping the patient at the hospital will mean that reimbursement will end. What should the case manager do?

As case managers, we sometimes are asked whether we advocate for the hospital or for the patient. I believe the correct answer is both, because we have to realistically balance the needs of both.

A difficult balancing act

In practice, we always favor the needs of the patient, while keeping in mind what's best for the organization as well. The balancing act can be difficult, and hospital case managers should not try to tackle these difficult ethical dilemmas alone.

Case managers may seek guidance from the Case Management Society of America (CMSA) Standards of Practice, as well as the code of conduct or ethics to which they are bound by licensing or certification.

In addition, case managers can use their chain of command as a tool to find the best solution. For individual case managers, this means turning to the department director or manager to whom they report. Physician advisors also may be asked to speak to the insurance company as an advocate, urging that the patient's stay be extended.

For case management directors and supervisors, the issue can be escalated to hospital

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administration or the hospital's ethics committee. As clinical, financial, and legal/ethical issues arise, more hospitals are turning to their ethics committees for advice. While these groups have often addressed end-of-life issues, we are seeing a growing trend toward the formation of organizational ethics subcommittees to address financial and reimbursement issues.

In the hypothetical example, if the insurance company would not authorize an extended stay, the hospital would likely absorb the additional costs. Legally and ethically, there is an obligation to keep the patient in the hospital until discharge is deemed to be safe. While this decision may be a costly one for the hospital, in this example, the extended stay is determined to be the best and safest decision for the patient.

When it comes to ethical dilemmas that confront hospital case managers, here are some key points to keep in mind:

- **Identify the issues.** What clinical, financial, and ethical concerns are raised by a particular problem or scenario?
- **Use the chain of command as a tool.** Turn to your supervisor, manager, or hospital administration for advice. Seek the input of the hospital's ethics committee. Bringing together the viewpoints and input of representatives from various departments in the hospital will help to bring about the best solution.
- **If the hospital does not have an ethics committee or a committee that will take legal and reimbursement issues under advisement, urge the formation of such a group.** In a managed care environment, given the sharp rise in health care costs, ethical dilemmas related to reimbursement likely will become more common.

Most important, case managers should know they are not alone as they navigate through the perilous waters of ethical dilemmas. They have others to rely on for guidance toward the safe harbor of the best decision for all involved.

In its column, the CCMC explores ethical issues for various areas of the case management field. We welcome your questions and feedback, by contacting us at info@ccmcertification.org.

[Toni G. Cesta, PhD., RN, FAAN, is director of case management at St. Vincent's Hospital, Manhattan and the consulting editor of Hospital Case Management. *She also is a commissioner for the Commission on Case Manager Certification (CCMC). The CCMC has awarded the certified case manager (CCM) credential to more than 26,000 case management professionals since 1992. The CCMC is the only certifying body for case management professionals that is accredited by the National Commission for Certifying Agencies. URAC also has determined that the CCM credential is a recognized case management certification. For more information or to obtain an application for the CCM, contact the CCMC at (847) 818-0292 or go to the web site at www.ccmcertification.org.]* ■

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. ■