HOSPITAL CASE MANAGEMENT™

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

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IN THIS ISSUE

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Creativity is the key to discharge planning for hard-to-place patients

Develop a relationship with skilled nursing facilities

Hospital discharge planners often have to use their ingenuity in finding placements for patients with no insurance who need post-acute services or are homeless and need a place to stay.

The problem is that patients must be discharged safely, whether or not they have money to pay for the services they need.

"Each case is slightly different, and we look for opportunities. The only way we can make sure it's a safe discharge is to tap into as many resources as possible," says **Caroline Keane**, RN, MSN, ANP, CCM, director of case management and social work for New York Hospital, Queens. The hospital is a private nonprofit hospital in downtown Flushing. If the indigent are documented and don't have behavioral issues, it's fairly easy to place them in a skilled nursing facility (SNF), she says. "We get a lot of patients who are on Medicaid. They are indigent in the short run, but they are the bread and butter for some nursing homes."

When patients are just over the financial threshold for Medicaid, the social workers at the hospital can refer them to community groups who provide free medical care or long-term care facilities that will take the indigent.

Case managing the uninsured

With the number of uninsured Americans at 45 million and climbing, hospitals must come up with creative ways to provide treatment for these and other patients who can't pay. In this issue, we'll look at some of the challenges that hospitals face and how case managers can help address them. You'll learn how home visits improve outcomes for young asthma patients. We'll show you how some discharge planners handled difficult-to-place patients and how going beyond traditional hospital services helped one hospital cut admissions for its most severely ill patients. ■

Undocumented workers are a big problem for hospitals located in urban areas. St. Vincent's Hospital in New York City has paid to transfer patients back to their home countries because they could not be safely discharged home and did not quality for post-acute services.

"If someone doesn't have a green card, they can't get continuum-of-care services. They can get urgent cardiac treatment or dialysis covered by Medicaid for brief periods, but if they cannot safely be discharge to home, it's a big problem," says **Kathleen Powers**, LCSW, discharge planning specialist.

Emergency Medicaid covers hospital care for these patients in New York, but they have no benefits for home care or nursing home care, creating a dilemma for discharge planners.

St. Vincent's paid $15,000 to send a young man back to China after he drank lye and ruined his esophagus and couldn't function. No nursing home would take him, and his family was back in China. "Ultimately, it was cheaper to send him back than to keep him," Powers says.

It cost $22,000 to send another undocumented worker back to Russia. "Nobody is comfortable taking people who are undocumented. There are some loopholes and some negotiating; and sometimes, we can work it out with some of the nursing homes. Each case is individual," Keane adds.

For instance, undocumented patients may be eligible for some services if they have paid into the tax system. "Sometimes, we are looking for free service. Home care agencies have a certain amount of free care in their budget. If someone is undocumented and going home, we may be looking at free durable medical equipment and free transportation home," she says.

Sometimes, undocumented people who are injured in a car accident are covered by the state's no-fault insurance. "Occasionally, we keep them here and do rehabilitation until it will be safe for them to go home. Sometimes, it's our only option. We never drop the ball. We always continue looking for something," she says.

Homeless patients who are independent, can walk, and don't need skilled services usually can be guided into the shelter system, Powers says. "We have to fax the agency information on the patients' medical conditions and guarantee that they are not infectious and that they are independent enough to manage on their own, even if they're in a wheelchair."

If patients need antibiotics and can't get into the shelter system, they're the hardest ones to get nursing homes to take. "We do what we can to get Medicaid in place while they are here. Sometimes, a SNF will take a chance and accept a patient for short-term antibiotics," she says.

The biggest challenge is elderly patients who lose the capacity to advocate for themselves and have to remain in the hospital for two months

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or more until a hearing in front of a judge who appoints a guardian.

"We do everything we can to avoid it. We try to find prior power of attorney. If there are no funds, we end up paying the cost of legal fees for the hearing; but while the patient is sitting here waiting for the court hearing or a place in a shelter, we do not get paid," Powers says.

The staff use their ingenuity to identify people who are mentally incapacitated and who come in as unknown. They may find the person's address and use the Coles Directory (an Internet directory service — www.colesdirectory.com) to find out who lives at that address.

"It's a lot of detective work. We call anyone in the building who has a listed phone number, hoping we can locate someone in the building who knows the patient or the next of kin. We've been really lucky in locating people this way," she says.

By establishing close relationships with local long-term care facilities and leveraging the amount of business they give them, Keane's department is able to place about 300 patients a month, some of whom have significant problems and little or no funding.

"When we give a nursing home a lot of business, they are usually willing to help us with the patients who are difficult. They know how much business we give them; and occasionally, they have to take a case that's less than perfect," Keane explains.

If patients are indigent and have a family who will who will work with the Medicaid system, the hospital usually can place patients with Medicaid pending. "If we know the application is good, there are facilities that will look at the full picture with us and decide if they are willing to take the risk," she says.

If a patient is medically stable but disoriented and has no one to advocate for him or her, the hospital works with nursing homes to set up a guardianship. Occasionally, the hospital handles the guardianship alone.

"We get as many referrals to as many skilled nursing facilities as we can as quickly as we can. We know who may be hungry enough to spend money to get the long-term guardianship in place," she says.

The hospital has a contract with Curaspan, a Newton, MA, provider of connectivity and network management, for its *e*Dicharge platform discharge planning solution.

The system allows the hospital to enter the patient information once into the *e*Dicharge database, which searches for available facilities.

"The system allows us to write the story once. We don't have to refax to everyone. We can widen the circle as we need to until we find a facility that will take the patient," Keane says. For instance, she was able to set up a SNF transfer for one patient without his ever being in her hospital.

The man was a New York City resident but was in Canada when he had a massive stroke. The wife came to Keane for help. "He was a laborer with no nursing home benefits, and he was on a respirator. We made referrals to about six facilities, using *e*Discharge and within four or five days, were able to airlift him from Montreal," she says. ■

Hospitals challenged by patients who can't pay

Charity care should be saved for the truly needy

Case managers, along with other hospital staff, are challenged today by an increasing number of patients who can't pay their bill.

As health insurance costs escalate and employers provide a lower level of coverage for employees or cut out insurance benefits altogether, the number of workers with no health insurance is on the rise. Meanwhile, states are struggling with dwindling funds for Medicaid and are slashing benefits, and an unprecedented number of undocumented workers are seeking care in hospital emergency departments (ED).

The situation has been brought to a head by class-action lawsuits filed against hospitals and health systems alleging that they are overcharging the uninsured. Some of the suits have been settled, with hospitals agreeing to provide discounted or free care to patients without health insurance whose incomes are up to 400% of the federal poverty level.

"In the last few years, we've seen the uninsured population keep inching up. Hospitals have to have some way to deal with it," says **Rick Wade**, senior vice president for communication at the American Hospital Association.

Patients who can't pay their hospital bills generally fall into four categories: the uninsured, the underinsured, indigent patients, and undocumented patients. **(See box, p. 4.)**

The problem of dealing with patients who can't

pay is universal, but hospitals in smaller cities have the advantage of knowing more about who is in their community and what their needs are than their big-city counterparts where there are ever-changing diverse populations, Wade says.

Hospital case managers need to understand the financial impact that patients who cannot pay have on the hospital and proactively help identify patients who may not be able to pay their bills, says **Mark Cameron**, MBA, CHFP, BA, MS, health care consulting manager for Pershing Yoakley & Associates in Knoxville, TN, a health care consulting firm with offices throughout the South.

Hospitals should take steps to determine a patient's ability to pay early in his or her stay. The patient should be treated first, but once the patient is stable or a relative is available, determining the ability to pay needs to be the next step. If patients can't pay the entire bill, discuss all options available for financial assistance and set them up on a payment plan if they don't qualify for assistance or charity care, Cameron says.

St.Vincent's Hospital in New York City has a nurse case manager on every unit who reviews the chart early in the stay, says **Kathleen Powers**, LCSW, discharge planning specialist. If a patient has no insurance or may be undocumented, the case manager sends a referral to social work for an assessment of the patients social and financial situation to see if he or she might qualify for an entitlement program or will be a private-pay patient.

If the patient may be eligible for Medicaid, the business office is notified and initiates a Medicaid application within 48 hours.

"We have written referral forms to the business office indicating the patient's name, location, family members' names, and information that they need Medicaid for home care or nursing home placement," she says.

Once a week, Powers has her clerical staff compile a list of everyone referred for a Medicaid application and meets with the business office to ensure the applications have been completed.

"[Those are] checks and balances to ensure that the patient account representatives are talking with social work and vice versa," she says.

Two senior citizen volunteers work out of an office in a hospital clinic and help patients explore their eligibility for entitlement programs and guide them in how to get services.

The volunteers have been trained to be familiar with entitlement programs and benefits by a local agency and have a manual with details about all the programs that are available.

The working poor remain a major problem because they can't qualify for Medicaid but they can't afford to pay their medical bills, Powers says. "We look at their situation on a case-by-case basis and try to see if their family can be of any assistance. If not, we try to hook them up with a clinic and get them on Medicaid if at all possible. It's often touch-and-go," she says.

Every hospital should develop policies for how to identify, evaluate, and deal with all patients who may not have the ability to pay, Cameron adds. Don't confuse care for the uninsured with charity care, he urges. Save your charitable resources for the truly indigent, and use your ingenuity to come up with ways to collect at least partial payment from the uninsured if they don't qualify for some

4 types of patients who may not be able to pay their bills

1. **The uninsured:** These are simply patients with no insurance. Most of them are the working poor who make too much to be eligible for Medicaid or other entitlement programs but who have no insurance. According to the U.S. Census Bureau, 45 million Americans had no health insurance during calendar year 2003, an increase of 1.4 million over 2002. However, some of these patients may be employed with large incomes and a wealth of assets. The Census Bureau found that 11.2% of uninsured people have family income of $50,000 or more, and 7.1% make $75,000 or more.
2. **The underinsured:** These are patients with low-paying jobs, high deductibles, and high copays. Their insurance pays for part of their care, but they don't have the money to pay for their share.
3. **Indigent patients:** These patients are either unemployed or work part time at poorly paying jobs. They have few assets and little, if any, income. Many of them may be eligible for Medicare or other programs but may not know it or may not know how to apply.
4. **Undocumented workers:** Patients without a green card pose a significant problem for hospitals. These patients often can qualify for emergency Medicaid assistance for acute care but don't have funds for long-term or follow-up care. They show up in the emergency departments only when they're very sick or seriously injured and may give false names or addresses because they don't want to be deported. ■

level of charity care, he says.

For instance, some hospitals give their uninsured patients a flat discount, commensurate with the discount they give to certain payers.

"Some of our clients are giving a discount to people who clearly have the ability to pay but who have no insurance. In this way, the organization consistently extends a discount to all uninsured patients to comply with established internal policies and prevent discrimination," Cameron says.

A hospital's charity care policy may determine patients who qualify for charity care by where they fall into federal poverty-level discounts. For instance, if their income is 200% of the poverty guideline, they may get free care. Those whose income is 300% or 400% of the guideline could get discounts based on a sliding scale.

Bringing up finances

When an uninsured patient registers, the hospital staff should work with family members and the patient to determine his or her ability to pay and should be able to explain to the patient what options he or she has.

"Hospitals need to establish solid financial counseling even if they have only a moderate volume of patients who need some assistance," he says.

If the patient comes to the ED, he or she should be seen and evaluated by a medical professional before the financial matters are brought up, adds Cameron.

It's a different story in other settings, such as inpatient care and outpatient surgery. If a procedure or hospitalization is scheduled and not urgent, the hospital should provide financial counseling before the treatment to avoid payment delays, he notes.

"There are very few people who don't want to pay for their care. They just aren't able," Wade points out. That's why hospitals are getting creative in working out arrangement for payment, often offering uninsured patients discounted care.

Hospital representatives shouldn't make people who can't pay feel guilty. "Unless people feel they have handled themselves properly, they may be afraid to return," he adds.

North Shore-Long Island Jewish Health System implemented a financial program for the uninsured in March, according to **Terry Lynam**, vice president for public relations.

The program provides assistance to uninsured patients who earn up to three times the federal poverty level but who don't qualify for any publicly subsidized programs.

"The first order of business is to make sure that someone who comes in with an emergency situation is treated. The issue of payment comes about later in the process when the patient is checking out or when the bill is sent," he says.

Patients who can't pay are urged to call a toll-free number and talk to a financial assistance representative. They are asked to submit verification of income and assets but the value of their home or 401(k) is not taken into consideration when they apply for financial assistance.

For instance, a patient at the top of the ceiling would pay 35% of the negotiated Medicaid fee for the same service. Patients who qualify for assistance pay a small fee for routine physician visits at the system's primary care clinics.

"Our health system has provided charity care for years for patients who lacked insurance, but we never had a formalized financial assistance policy that took into account each individual's ability to contribute," he says.

In the past, someone who was uninsured would get a bill at the full charge, typically a higher rate that what was negotiated with Medicare and Medicaid HMOs. At that point, the hospital would try to negotiate a reduced fee.

"If people are looking at a $10,000 bill representing full hospital charges or they're looking at a $2,500 bill and they are given the option of setting up a payment plan, most people will make a legitimate attempt to pay the bill. One of the problems of the past is that people were so staggered by the size of the bill that they were scared off and tried to avoid payment at all costs," he says.

In 2004, the hospital system's charity care and uncompensated care totaled $200 million, about half of which was bad debt.

"If we can collect even 35% of what Medicaid typically pays for a service, it's not an insignificant amount of money," he says.

Just because a patient falls within a certain level of income, that doesn't mean there is only one option. Options could be a payment plan, a contract with a finance company, charity care, or a community-based program that is not Medicaid, Cameron says.

Hospitals are trying various strategies to help pay for care for their indigent, uninsured, and underinsured patients.

Some hospitals have established relationships with finance companies that assume the liability for the patient's bills and extend credit. The finance

company pays the hospital and bills the patient.

"It may be an advantage for a hospital to enter into a relationship such as this," Cameron says.

However, if the patient doesn't have a steady job and has few assets, the finance company may not be willing to extend the credit, he points out.

Some hospitals have worked with local school systems to find children who qualify for community programs and have developed working relationships with churches, schools, local organizations, and community leaders to help people understand how to access the health care system in the most efficient manner.

"The message can't be 'stay away from the hospital.' It should be for them to get care in the right setting," he says.

One community hospital has come up with a barter system for its uninsured patients, Wade says.

Patients who can't pay can opt to donate time to the hospital to help cover the cost of their care. For instance, a landscaper may work on the hospital grounds, or a computer programmer may volunteer in the hospital's computer center.

"If you need care and you don't have the insurance to pay for care, the hospital will work with you," he adds. ■

Establish a special area for nonurgent ED patients

CMs should triage patients to proper level of care

The sign over your emergency department's (ED) door may say "emergency," but the people who walk in may not necessarily be having one.

"The emergency department has become the gateway for everything, particularly among the population that is not insured. Hospitals are having to become creative in finding a different level of care for these patients," says **Rick Wade**, senior vice president for communication at the American Hospital Association.

A nonemergency clinic located near the ED and staffed by a nurse practitioner or physician assistant working under the supervision of a physician is one solution to the problem, he adds.

The clinic is part of the hospital but functions more like a physician's office.

The cost for treating patients is lower because there's a lower level of staffing than in the ED.

Once the patients are assessed, if their conditions are not urgent, they may be sent to the nonurgent clinic. That gives the case manager an opportunity to educate the patient to see a primary care physician if the same condition occurs in the future.

"The nonurgent clinic is particularly helpful on weekends and during peak times because nonurgent patients get care but they don't create delays for people who truly have an emergency," he says.

"Case managers are a hospital's primary line of defense in triaging patients to the right level of care. They not only understand the type of care the patient needs but they can communicate effectively and efficiently with the physician and the patient," says **Mark Cameron**, MBA, CHFP, health care consulting manager for Pershing Yoakley & Associates in Knoxville, TN, a health care consulting firm with offices throughout the South.

If ED case management works hand-in-hand with clinical staff in the nonurgent care area, it allows patients who do not have an emergency to be treated at more appropriate level of care by a nurse or a physician assistant and keeps the highly trained clinic staff available for a true emergency which can reduce resource costs, he explains.

Case managers should approach patients who come to the ED with nonurgent conditions and work with the treating clinician on developing a treatment plan that would keep the patient from coming back to the ED for routine matters, connecting them to physician offices, home health services, and other resources, he adds.

"The key is on medical screening and triage. If there is a question, the decision needs to be made by the physician or physician assistant in charge," he says.

Cameron suggests that hospitals create a checklist of conditions that could qualify patients for the nonurgent care area. If there is any uncertainty, the case manager should check with the physician or physician assistant.

"Having protocols in place allows the emergency department triage staff to go through symptoms and chief complaints and identify a lot of nonurgent patients in the process," says Cameron, cautioning that in some cases, the case managers should alert the physician to rule out that there are no serious underlying causes for the symptoms. ■

Education decreases ED visits for young asthma patients

Team works with patients and families

A pediatric asthma program that includes home visits by an asthma management team and an intensive educational program for families has resulted in a dramatic drop in emergency department (ED) visits for pediatric asthma patients at Hurley Medical Center in Flint, MI.

"Pediatric asthma is the No. 1 reason that children are admitted to the hospital throughout the country; but in our county, it has become the No. 3 reason for juvenile hospitalizations since we began our pediatric asthma case management program," says **Jan Roberts**, RNC-AEC, pediatric asthma disease manager.

The pediatric asthma case management team consists of Roberts and another nurse and a social worker. Roberts is a certified asthma educator.

The team works with the young patients and their families to help them better understand the disease and how to control it, including educating them on appropriate use of medications, improved compliance with treatment plans, and better control of environmental triggers.

Assessing patients and following up

Home assessments and follow-up visits in the home are a key to the success of the program, Roberts says.

The team has found that making home visits was more effective than just sending out literature and conducting disease management by telephone.

"The improvement increases with the level of intervention. If the families receive just a phone call and a packet of educational material, it makes a difference, but not as much difference as when they receive home visits," Roberts says.

Whenever possible, the case management team visits the home of every patient in the program. The team conducts a home assessment, going through the home from top to bottom and identifying asthma triggers.

If the family is uncomfortable with the assessment, the team may postpone it until a subsequent visit or may look just in the child's room.

Initially, all members of the team visit the home. Follow-up may be by only one team member.

The goal is to help the families learn about asthma and make sure they have no barriers to optimal treatment, resulting in a decrease in ED visits, hospitalizations, and school absences.

"At the home, we determine what their needs are, whether they need help with insurance, if they know what medications to take and when, and if they have an asthma action plan," Roberts explains.

The interventions are physician-driven and patient-driven, depending on what the patient needs.

"Some need just two home visits with a lot of education. Others need a monthly phone call and some may need a monthly or bimonthly visit," she adds.

If the case management team is having trouble getting a child's asthma under control, it has a team meeting with the physician and other clinicians, the parents, and anyone else who might have input into what can be done for the child.

In many cases, the patients are not using their medication properly. They get their daily medication and their rescue medication confused.

Home visits may be as short as 15 minutes or as long as 1½ hours.

"The visit can overwhelm the clients, and we break it up into segments," she says.

Patients and their families respond well to home visits because they are on their own turf and feel more comfortable than in a professional setting, Roberts says.

Visiting the home gives the case managers an opportunity to structure their teaching around what kind of asthma triggers may be in the home and allows them to see if there are other issues with which the family needs help.

"We make sure the family's basic needs are being met. People won't worry about asthma if they don't have any food. We help them get food or help with their utilities and then worry about asthma," she says.

In the case of teenage patients, who often are reluctant to use their medication, the team comes up with a contract, asking them to try to follow the treatment plan for a month so they will see the difference it makes.

"If they try it for a month, they usually buy into the program because they feel a lot better," Roberts says.

The team goes to local schools and instructs teachers in the classroom on how to respond early on.

"If the teacher knows what to do when a child seems to be getting into trouble, she can help the child avoid a visit to the emergency department," she says.

Many of the young asthma patients who come into the ED have no insurance coverage. The case managers work with the family to get insurance through state-funded programs. In some cases, a state-funded program will pay for a one-time diagnostic visit and will cover only asthma treatment.

They tap into community resources that provide coverage for medication and primary care physicians.

"Some children with insurance need it because their families may not have the money to cover copays or prescriptions," she says.

Many of the families are qualified for Medicaid and don't realize it. The asthma management team works to get them qualified.

"We want to eliminate all barriers to getting the medication they need," Roberts says.

If there are no other options, the asthma clinic supplies the patients with asthma medication samples.

Most of the patients are referred by their physicians. The program also takes referrals from any patient younger than 18 who has been in the ED for asthma. ■

WebM&M teaches by example with case studies

Site draws quality managers, safety professionals

"One of the great challenges in the whole world of quality and patient safety is learning to take advantage of the richness of clinical cases," says **Robert M. Wachter**, MD, professor and associate chairman in the department of medicine at the University of California, San Francisco (UCSF) and chief of the medical service at UCSF Medical Center.

"It's a great challenge whether you are a doctor, nurse, risk manager, quality leader, hospital CEO, or a therapist," he says.

Wachter says he is beginning to believe that AHRQ WebM&M (http://webmm.ahrq.gov), an on-line journal (of which he is the editor) and forum on patient safety and health care quality sponsored by the Agency for Healthcare Research & Quality, is accomplishing just that.

Launched early 2003, WebM&M features:

- expert analysis of medical errors reported anonymously by readers;
- interactive learning modules on patient safety ("Spotlight Cases");
- forums for on-line discussion.

"It's grown incrementally over time, exceeding expectations," says Wachter, who notes there are about 7,500 registered users and 700 unique visitors to the site daily. What's more, he notes, the average visitor stays on site for 12 minutes, "so it's likely they're reading the information," he observes.

That seems to indicate the site has achieved one of its primary goals, which was to make its case commentaries relatively brief and nearly jargon-free. "We did not want it to feel plodding and academic," Wachter explains.

Patrice Spath, a consultant with Brown-Spath & Associates in Forest Grove, OR, also is impressed with the site.

"What makes it different from many other health care-related web sites is that this one is specific to what the health care professional needs to

do to improve patient safety," adds Spath, who serves on WebM&M's advisory board.

"It is constantly updated with new ideas, and has a high caliber of advisors. Also, there's a very systematic, scientific analysis of the incidents they present — not just random commentary," she continues.

In numerous discussions with health care professionals, Wachter had noticed a common theme.

"What I would hear as we'd go from hospital to hospital is something like this: 'We had this particularly troubling and interesting case, but we can't even figure out how to get the information to our other units or departments,'" he recalls.

"AHRQ's and our epiphany was that there is a tremendous richness in clinical cases, but no one had figured out a way to present them as real and in a manner that was accessible, lively, and useful. I honestly don't think anyone else does it," Wachter explains.

By using the web interface, people can send the site cases anonymously from anywhere in the world, he notes. "Through AHRQ's resources, we are able to compensate case submitters, which gives them an incentive to submit and enables us to engage the world's experts."

For example, if a case is submitted on a medication error or on wrong-site surgery when staff consider who the best person would be to provide expert discussion and commentary, they usually can get them.

"Plus, we have a strong editorial team, and all cases read well and in an interesting way," adds Wachter. "We work hard with the authors to be sure they are as engaging, as practical, and as interesting as possible."

Quality managers taking advantage

While WebM&M originally was oriented toward physicians, a survey this past May indicated the following breakdown: 24% were nurses; 21% were physicians; 4% were pharmacists; 11% were health care administration/managers; and 32% fell into a broad category that included quality managers, risk managers, systems engineers, and ethicists.

"It was equally split between providers and nonproviders," Wachter notes. When asked to rate the educational value of the site, 75% of the respondents rated it as "excellent."

There are many ways quality managers can and should use the site to improve performance, he says. "For one thing, this field is so broad I don't think anyone knows *all* they need to know. The average quality manager or leader or risk manager will learn from the site because the cases we've posted range from psychiatry to surgery and safety problems, and from wrong-site surgery to errors related to implementation of IT to cognitive psychology and teamwork."

Just as importantly, Wachter says, it can be used to spread education across hospital silos.

"Many [quality managers] have taken to sending an issue or an individual case and mailing the web link to a doctor or nurse on the patient safety committee, because they believe they can learn from it," he notes. "Then, somebody who might not have gotten the journal might pick it up and then be hooked."

Each month, there is a spotlight case presented with a PowerPoint slide set. "Many people use that as a way of starting each month's quality or patient safety meeting; if you're looking for teaching materials, we've done some of the work for you," Wachter adds.

Spath agrees. "There are two ways quality managers can use this site. First, they can download the PowerPoint from the feature case and use it at patient safety committee meetings, staff meetings, and so forth as a learning tool. But perhaps a more powerful way of using it is something I've been teaching people to do, which is a technique called, 'Could this happen here?'" she points out.

The technique works like this: The case is reviewed and discussed, and group members are asked whether a similar event could occur in their organization. "If the answer is that it could, you then ask what would have to go wrong for it to happen." The response tells her a lot about the culture of an organization, she explains.

"If people look at the case and say it could *never* happen, that tells me they are not willing to admit that mistakes can happen, which is a significant culture problem," Spath says.

Using a case from another facility has an additional advantage, she explains: It takes known faces and names out of the equation, allowing staff to talk about problems they have a little more objectively.

"If you say, 'Here's what happened because of an error by Nurse B,' that puts a face and personalities to the incident, and you can't get past that to talk about underlying system issues," Spath observes.

"In this method, people do not feel so threatened, and therefore, they don't feel the need to

try and protect themselves," she says.

Once the potential for error is identified (what would have to go wrong), the next step is to show how it can be kept from going wrong, Spath adds.

"That leads to process improvement," she asserts. "Because these incidents are presented in sufficient detail, it makes them even more valuable for a 'Could this happen here?' exercise."

"These cases hold lessons for individual institutions," Wachter concludes.

"Every one has an incident report, a root-cause analysis, and we're all struggling with the same problem — how to take the power that lies in individual cases and get it to the diverse group of people that need to know about it," he adds. ■

Insurer refuses to pay for wrong-site/person surgery

The movement to prevent wrong-site or wrong-person surgery got another boost recently when a major health plan announced affective Jan. 1, 2005, it will no longer pay for medical procedures involving those egregious errors.

Don't expect to get paid for a procedure if you leave that 12-inch retractor in the patient's belly, or the next procedure to remove it.

HealthPartners, one of Minnesota's biggest health plans, announced recently it would not pay for procedures involving never events — those mistakes so serious and preventable that they should be eliminated entirely, not just reduced.

George Isham, MD, medical director for HealthPartners, says, "We all agree that patients should not pay for medical care made necessary by one of these errors. This is especially important as consumers are asked to bear more of the costs of their care premiums, deductibles, and copayments."

Noting that some hospitals already waive the costs associated with these errors, he says HealthPartners wants to "work with hospitals, physicians, nurses, and others to make sure this is the case for every patient, every time."

Isham notes that the new HealthPartners philosophy extends to all serious, preventable adverse events. Wrong-site surgery is just the most obvious example, he says.

HealthPartners provides health coverage to 630,000 members and has a network of physicians and hospitals, including HealthPartners Clinics. It is the state's third biggest health insurer, after Blue Cross and Blue Shield of Minnesota and Medica.

Providers in Minnesota have been required to report adverse events since July 2003. Isham says there have been 40 adverse events in the first 10 months of reporting from 15 hospitals that contract with HealthPartners. Of those 40, 14 involved care management and 18 to surgical procedures. The surgical events involved 10 incidences of surgery on the wrong site or wrong patient, or the wrong surgical procedure.

The new policy will require any hospital contracting with HealthPartners to report serious adverse events within 10 days, giving the insurer time to identify the procedures it will not pay for before the end of the billing cycle. ■

CE *questions*

1. St. Vincent's Hospital in New York City has paid thousands of dollars to send undocumented workers back to their country of origin because they didn't qualify for post-acute services and couldn't be safely discharged to home.
   A. true
   B. false
2. According to the Census Bureau, how many Americans had no health insurance in 2003?
   A. 20 million
   B. 45 million
   C. 60 million
   D. 32 million
3. A study by San Francisco General Hospital shows what percentage of patients had 3 or more hospitalizations in a 12-month period?
   A. 13%
   B. 20%
   C. 5%
   D. 30%
4. The pediatric asthma case management team at Hurley Medical Center in Flint, MI, consists of Jan Roberts, RNC-AEC, pediatric disease manager, and what other team members?
   A. another nurse and a social worker
   B. three hospitalists
   C. a utilization reviewer and a discharge planner
   D. all of the above

Answer key: 1. A; 2. B; 3. A; 4. A

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HMSA case managers are patient advocates, not UMs

System promotes collaboration, not competition

Case managers with the Hawaii Medical Service Association (HMSA), a nonprofit medical indemnity association, follow a practice model that differs significantly from that used at most other insurance companies, says **Melissa Bojorquez**, ACBSW, MBA, CCM, supervisor for the HMSA case management program.

That difference may have something to do with why HMSA — the independent licensee for Blue Cross Blue Shield for the state — was chosen to receive the March of Dimes Franklin Delano Roosevelt Award for Distinguished Community Services. A video, *Circle of Healing,* which was made in connection with the award, depicts HMSA's handling of four different cases in which its members were faced with devastating illness.

"In some settings, case managers are also utilization managers," Bojorquez notes, "but it's difficult to represent the patient if you're playing that role. In our model, we don't place case managers in that position. Our case managers aren't necessarily the decision makers, but rather the facilitators."

Case managers serve as patient advocates, she explains, working toward the best possible plan of care. Decisions on whether to cover a particular treatment are made by the HMSA medical director, Bojorquez adds.

"Sometimes our case managers have to deliver not-so-good news," she says, "but we try to move beyond what's not payable to, 'How can we access the care we need for the patient? Do we need to transition to another community funding source, another program?' It's important for us to say to the patient, 'Here is the outcome, and I know it isn't what you expected, but can we move forward?'"

Through such efforts, she notes, "our organization has played an important role in making health care affordable from a member and an employer group perspective."

Another advantage of having health plan case managers, Bojorquez points out, is that they can follow members from multiple locations. "They can follow a member from the hospital to a rehab facility to home care to independent living or assisted living," she adds, "an advantage that case managers in specific facilities or settings do not have."

One of the cases cited in the March of Dimes award involved an infant who was born with a nonfunctioning bowel and ultimately had to be sent to a West Coast facility for a small bowel transplant, Bojorquez says.

"That took a lot of coordination, with a member going out of state who had to be supported in an unfamiliar area," she says. "The case manager was there to support the family throughout the process."

The case manager worked with utilization management to preauthorize the treatment, which involved determining that the facility was a "Blue Quality Center for Transplant" under the Blue Cross Blue Shield "center of excellence" requirement, Bojorquez adds. "There was a lot more coordination and research than with organs like livers or hearts that are more commonly transplanted."

In addition to being a conduit of information for issues within HMSA, she says, the case manager worked with outside payer sources to seek coverage under other programs for which the child might be qualified. For example, it costs between $35,000 and $50,000 to transport a critically ill patient from Hawaii to the mainland, Bojorquez explains. In this case, that expense was covered by another agency.

That child's care is ongoing, with trips back and forth between facilities in Hawaii and California, she says. "The family is very appreciative of the case manager. They think of her as a friend, someone to call for advice."

What makes Hawaii unique

One of the factors that makes Hawaii's health care environment unique, Bojorquez explains, is that the state's Prepaid Health Care Act requires employers to provide insurance to any person working 20 hours or more per week, she adds.

Because of that requirement, it is not uncommon for case managers to have to coordinate care and services that have coverage by several insurers, Bojorquez says. When a case involves coverage by more than one health plan, she adds, the coordination of benefits can be complicated.

The unique nature of the HMSA model allows case managers to take a cooperative approach when it is necessary to navigate between two plans, she points out.

"It might be two competitors — HMSA and Kaiser, for example — working together, but the issue is how best to coordinate the patient's care, not to try to avoid being the one to pay for the care."

In many cases, Bojorquez notes, "[the other insurer] covers part of the care, and we cover part of it." Because of the universal nature of coverage in Hawaii, she adds, "there is no need to be adversarial. We can work collaboratively."

With about 60% of the market and 670,000 members out of a population of nearly 1.3 million, HMSA is the largest insurer in the state, she says. "Kaiser is next, and union plans or third-party administrators have the rest."

HMSA has been part of the Blue Shield Association since 1946, and since 1990, has been the independent Blue Cross Blue Shield plan for the state of Hawaii, Bojorquez explains. The case management program has been in place since 1988, she notes, sparked in part by needs associated with the AIDS epidemic.

With advances in medical technology that support home care of the complex medical patient, she says, "there needed to be a unit that assisted members with these types of catastrophic treatments. We needed a program to review the appropriateness of home services that were in lieu of being in the hospital."

In seeking to fill those needs, the HMSA program evolved from individual benefit management to a more focused care management model, adds Bojorquez, "always with the intent of helping members with complex care needs."

HMSA was founded in 1938 as what is known as a mutual benefit society, she explains. "It was started by social workers, teachers, and nurses because of the need for affordable health care in the community. We now have different types of benefits, but a lot of our role is navigating members on how best to use their benefits."

Members pay dues to the nonprofit organization, Bojorquez explains, and it is managed by a 27-member community board that serves without compensation. "Insurance is the primary product, but there is a range of other programs for which HMSA has been the catalyst. We still have the mission of bringing quality, affordable health care into Hawaii."

Among other services, HMSA provides disease management, preventive health, health education, and screening programs, she notes. In some instances, Bojorquez says, the organization's role is bringing in or helping providers to develop services that aren't in the community, and establishing a reimbursement model.

Nurses were the basis of the case management program when it started, she points out, but the agency progressed to a nurse/social service or care coordination model. "That was because a lot of the need was not always for treatment of the disease but for the coordination of resources and services."

What happens today

Now the case management program refers to and coordinates with HMSA's disease management program for the education and management of chronic health conditions, she says, as the HMSA case management staff focuses on members with serious and/or chronic long-term illness, those with complex placement/social needs, and children or elderly patients who are medically fragile, among others.

"We are addressing the needs of the patients, but we are also putting a lot of effort into assisting the families, because they are the caregivers," Bojorquez adds. "We look at what is needed to help maintain the patient at home. Another program might be more concerned with clinical aspects, compliance with protocols. We look beyond that."

Palliative care, education of advance directives, and transition to hospice care are among

the program services, she notes. "Our highest volume is oncology, and we have a lot of patients who are at the end stages of disease or who are suffering from life-limiting disease.

Once the patient is taken care of by the appropriate providers, the issue is, 'How do you support the family? Are they at risk of breakdown? Do they need respite care?'"

In addition to Bojorquez, the case management staff includes **Linda Dullin,** RN, senior case manager, and four social work case managers, she says, as well as the medical director.

Dullin performs the first level of clinical review for all referrals. The referrals, which come by telephone, fax, or e-mail, are fielded by an HMSA intake specialist, who takes the information on the referral, checks eligibility, puts the appropriate medical and plan/benefit documents together, and sends them to Dullin.

Most referrals come from within the organization, Dullin says, whether from a member, a member's family, or another facet of HMSA, such as the disease management program. Physicians account for the smallest volume of referrals, she adds, but HMSA hopes those numbers will increase.

"Usually, our members have far more contact with a physician than with HMSA, and the physician is aware when someone has a particular need," she notes. "Who better to get that information from than somebody who's right in the thick of it?"

Physicians sometimes think of case management as being utilization management, Bojorquez says, and because they fear case managers will take an adversarial approach, they are reluctant to seek their help. "They shouldn't be," she adds. "We want to be an adjunct to their care of the patient."

The program would welcome more referrals from hospitals that are providing care to HMSA members, Dullin notes.

"Case management technically is a benefit, but most members don't realize that," she points out. "We might be able to say, 'This person has skilled nursing benefits. Rather than discharging the patient to a home that may be unsafe, why don't we send him to short-term rehabilitation facility so he can get stronger and have physical therapy?' A lot of times that was never thought of."

Once a referral comes in, Dullin explains, she reviews the material available, and if she can't make a determination, requests additional information. "If it's, say, a premature infant, with potential special-needs coordination, I will ask the hospital to send admission history and physical and consultation notes."

If a physician is making the referral, and Dullin has the information on the recent hospital stay but knows there were pertinent care events before that, she will contact previous providers.

"Because we're part of an insurance company, we don't run into as much difficulty with HIPAA [the Health Insurance Portability and Accountability Act] privacy requirements as some might think. When a person is admitted, part of the [privacy notice that is signed] allows release of their information."

Interestingly, she often has to "remind the provider that we are the insurance company," Dullin says. "I don't hesitate to put the request in writing, just to reassure the provider. We also send a copy to the member, because one of the things you're supposed to be able to do under HIPAA is go to the insurance company and find out to whom your medical information is being released."

After looking at the clinical implications of the additional information she has requested, Dullin says, she sometimes still needs to talk with the member or his or her family to determine, for example, if there is home care of any kind or a private caregiver.

"If we're talking about getting community resources, I want to find out what they already have in place," she says. "We want to empower them as much as possible.

"Our case management is to help them navigate and coordinate and maximize benefits, but we also work with them on what they want to accomplish," Dullin points out. "Unless we ask what they want and they tell us, the goals become our goals and not those of the members."

When she completes her evaluation of the case and determines that the person is appropriate for case management, Dullin gives the assignment to one of the social work case managers, she says.

Rather than just handing over a file, Dullin adds, "I try to give the case manager an overview of the case. All the information is in the hard copy, but I give them a highlight, something to put a face on it."

It's a team effort

A team approach extends throughout the HMSA organization, Bojorquez notes.

At the intake level, Dullin looks closely at cases to determine if they should be diverted

to the disease management or behavioral health programs. "Our whole intent is not to duplicate something that is already in place," she says.

"It's not unlikely that we might have a member who is diabetic, has congestive heart failure, and is at risk for end-stage renal disease and depression," Bojorquez says. "Is that person going to have four case managers?"

Case management rounds

Representatives from the different programs meet monthly to discuss complex cases, decide who has the best relationship with the member, and make that person the lead for the case, she says.

"The others take a back seat, and she becomes the primary contact," Bojorquez explains. "The patient might remain on other caseloads, but to avoid duplication of services, those case managers don't touch the case without coordinating with the lead case manager."

Meanwhile, the entire case management staff meet weekly for "case management rounds," she continues. "We present cases and give each other feedback. It's a vital piece of the program."

If a case is complex, or there may need to be a referral outside the network, Bojorquez adds, someone from HMSA's clinical review area may join the discussion.

The smallness of the unit engenders a strong camaraderie, Dullin says, with staff members often asking each other, "Have you ever had to deal with this?" or "What's your recommendation?"

"Our work in case management is hard at times, but in the majority of cases, the results are favorable for both patients and family. The job provides a real sense of satisfaction," she points out.

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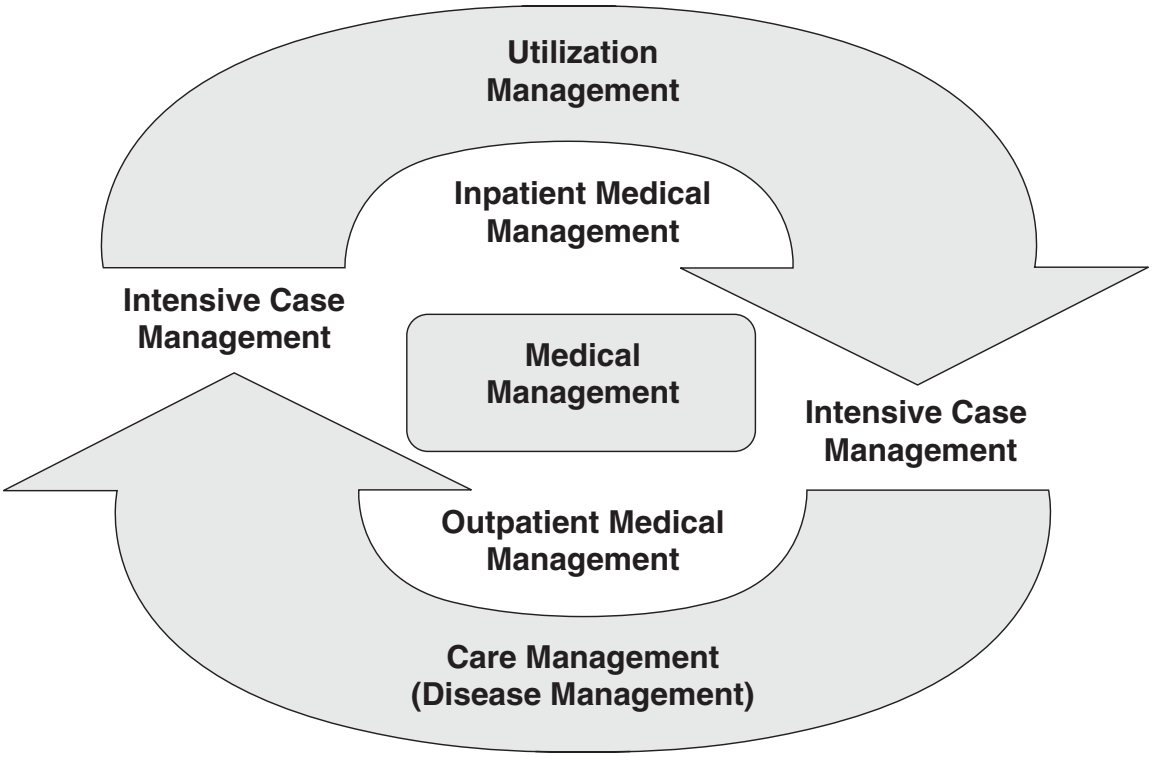
Differentiating UM, DM, and Case Management



This graph describes the interrelationship among utilization management, disease management, and case management in the HMSA model.

Source: Hawaii Medical Service Association.

Team approach cuts costs for the chronically ill

Efforts go beyond traditional hospital care

A team approach and intensive case management of patients has helped San Francisco General Hospital cut the number of hospitalizations and costs for patients who were frequently hospitalized.

The team's efforts go far beyond traditional hospital care and may include help with housing, transportation, and other barriers to obtaining health care. They help the patients navigate the complex and confusing social and health care system.

Among the first 15 patients who stayed in the case management program for a year, admissions were cut in half and median hospital days per patient dropped from 23 to 10.

The program started as part of the hospital's efforts to determine why some patients were dropping through the health care safety net.

"When we studied our patient population, we found that a very small percentage of our overall population drives 45% to 50% of the cost. About 80% of the patients have had one hospitalization in a year, but 13% had three or more hospitalizations within a 12-month period of time," says **Elyse Miller**, LCSW, clinical director for the medical high use case management program at San Francisco General Hospital.

The study determined the patients were overusing the primary care clinics and overusing the inpatient ward and developed a multidisciplinary team to tackle the problem.

The team includes Miller; the clinical directors; Michelle Schneiderman, MD, a medical director; three social workers, Ana Carcamo, MSW, Suzane Hufft, MSW, and Donn Warton, LCSW; a part-time psychiatrist, William Mains, MD; and a full-time nurse, Lin Zenki, RN.

The team meets twice a week for medical rounds, once a week for staff meetings, and once a week for a seminar to either discuss patient care or a didactic on medical or psychiatric issues.

"We are a roving multidisciplinary team. We go to patients' homes within the community if that's what it takes," she says.

The team recruits inpatients and asks them if they would like to participate in the program. Patients must set goals for themselves and agree to certain medical goals. "It's a matter of collaboration and compromise," Miller adds.

Each day, the team receives a computer-generated report of patients who were admitted the previous day and who have had three or more admissions in 12 months. The social workers visit the patients in the hospital, screen them, and try to recruit them. Inpatient social workers, physicians, and public health nurses also refer patients to the program.

Patients eligible for the program cannot be enrolled in another program that duplicates the services and must have a life expectancy of at least six months. The program is voluntary, but the patients have to agree to set goals and to be motivated to try to reach them. The social worker case managers typically carry a caseload of just 15 patients because of their intensive needs and complicated medical conditions.

"These patients have multiple impairments, significant medical issues, and underlying psychiatric and substance-abuse issues. Most of their chronic medical issues**.** such as congestive heart failure, diabetes, and chronic obstructive pulmonary disease, are compounded by drug and alcohol use," Miller notes.

Two-thirds of the patients are or have been homeless or marginally housed. About 80% have a mental illness, and 90% have alcohol and substance-abuse problems. The patients' care is too complex for a primary care physician to address during a standard clinical appointment, she adds.

Many of the patients have low literacy or a low educational level. Some have sustained multiple impairments that make it impossible for them to be organized. "These are patients with a low level of functioning but with a high level of need to follow up with their care. They need to complete a significant number of appointments with the specialty care clinics and take medication daily," she says.

The team was set up to facilitate the existing system, rather than creating a separate system to

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manage the patients' care. It works with the primary care physician, who delegates part of their responsibility for the program.

The team acts as a system translator and breaks everything the patient must do into steps to make it easier for the patient to follow. For instance, the team simplifies medication management, a significant problem for the population in the program.

When patients enroll, the case managers get a list of all the medications the patient is taking. The nurse organizes all the medications the patient is taking in a box with compartments for different times of day. "Some people are on 10-plus medications that they take four times a day. It would be challenging for someone with a college education without significant substance issues. It's impossible for our population, and they are set up to fail," Miller explains.

The team works with the primary care physician to simplify the medication schedule to make a significant difference in the patient's symptoms and be the most efficient for the patient to adhere to. For instance, instead of taking medications four times a day, the patient may be able to take it twice a day. The nurse puts the medications for the morning in one side of the box and the evening medications in the other side.

"Maybe the patient is only 80% adherent, but that can make a huge difference," she says.

The team helps patients get transportation to and from the physician or clinic and helps them get a medication card. "We do a lot of simple things that can make a tremendous difference," Miller says.

Finding stable, permanent housing is a big challenge. "In San Francisco, housing is difficult for the mainstream population; but for someone on SSI or general assistance, it's almost impossible," she admits. Finding safe housing takes the longest amount of time. The city has supported-living hotels for people who meet certain criteria, for instance those who need mental health services or medical care. "The social workers keep up with which facilities have availability and make sure the patient's names are on the waiting list and that the paperwork needed for admission is done.

"Housing is hard to find, particularly housing with a support staff. A single-room occupancy hotel is $600 to $700 a month, and the average disability check is $849. That doesn't allow for much padding. We try to get them into subsidized hotels, where the rent is one-third of their income," Miller explains.

If the patient has enough medical or psychiatric issues to qualify, the team may work to get the patient switched from general assistance, a welfare program, to another program that will provide a higher level of assistance, so he or she can qualify for MediCal.

"All of these little things can make a huge difference in a patient's enjoyment of life and can make a difference in their hospitalization patterns and the cost of their care," Miller explains.

The team is flexible enough to work with people who live an alternative lifestyle. "Instead of trying to push them into a mainstream process, we try to meet them where they are, get their medical symptoms stabilized, deal with their psychological issues, and get them on the right medication," she 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. ■