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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Take care to give patients a choice of needed post-discharge services

Final CMS rule sets penalties for noncompliance

Your hospital could lose its Medicare or Medicaid certification if you don't take care to ensure that patients who need home health services or a referral to skilled nursing facilities are given a choice of providers and not just steered to those in which your facility has an interest.

The Centers for Medicare & Medicaid Services (CMS) issued additional conditions of participation in Medicare and Medicaid programs in August. This means violations of patients' rights to freedom of choice could result in penalties for hospitals that don't comply, according to **Elizabeth Hogue**, a Burtonsville, MD, attorney in private practice, specializing in health care. "If a hospital violates the conditions of participation, it faces the possibility of decertification from participating in the Medicare and Medicaid programs," she adds.

Provisions of the Balanced Budget Act of 1997 require hospitals to provide information to patients who need home health and to avoid steering patients toward their own post-discharge agencies.

The new conditions of participation, which went into effect Oct. 1, 2004, incorporate the requirements of the Balanced Budget Act and make them applicable to patients who are discharged to skilled nursing facilities as well.

Hospital case managers and discharge planners should ensure their hospital is more than just technically compliant with the rule, Hogue suggests. "What we really need is compliance with the spirit of the law. Hospital staff should be approaching patients in a manner that helps them make a choice but clearly leaves the choice to them," she says.

Some hospital discharge planners may face pressure from the hospital administration to make referrals to the hospital's own agencies, Hogue notes.

Pressure from above is a tough issue for discharge planners, adds

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Hogue, who suggests going up the chain of command with information about the CMS rules and trying to make sure the hospital complies.

Most of the time, administrative pressure to steer patients to the hospital's post-discharge services is because of a lack of understanding on the part of the administration, she explains. That's why case managers should make sure everyone in the hospital understands the institution's certification is at stake if the rule is violated, Hogue adds.

"If the hospital administration continues to insist that patients be referred to the hospital's agencies in violation of the CMS rule, the discharge planner would be well advised to look for another job," she notes.

Individual case managers have a lot at stake as well if they are found to be in violation of the CMS rule, Hogue points out. The Case Management Society of America's national standards of care call for case managers to advocate on behalf of their patients. Referring a patient to an agency because your boss says so is interfering with your ability to advocate, she explains.

If a patient files a complaint with your discipline's governing body in your state, showing that you violated the regulation, you could face disciplinary measures, Hogue stresses.

Case managers who are certified face the possibility of losing certification if they violate the patient's right to freedom of choice, she adds.

Hogue points out that hospitals are obligated by more than just the CMS rules to provide discharge options to patients. "Court decisions that patients have the right to choose the care provided to them have been around for a long time."

In addition, there are two federal statutes — one for Medicare and one for Medicaid — that guarantee beneficiaries the right to choose their providers, she adds.

In issuing the final rule, CMS continues to give hospitals flexibility to present lists of providers in the most efficient and least burdensome manner for their particular facility. The rule does specify that patients receive a list of skilled nursing facilities and home health providers who have asked to be included and that the list indicates which ones are affiliated with the hospital and which ones are Medicare-certified.

The fact that the patient was given a choice must be included in the medical record.

CMS strongly recommends that patients who need to be in a skilled nursing facility be placed close to the patient's home and family, but it also mandates that the list of skilled nursing facilities include providers in the area where the services are likely to take place, even if it's not near the family's home.

"Patients may have to take what is available, especially if they are Medicaid patients," Hogue adds.

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Many discharge planners ask patients to sign a document saying they have been given a choice, she says. "In terms of documentation, this may be helpful, but I know from experience that the patients may not remember that they were given a choice."

Hogue recommends that discharge planners create a standard list of all providers and use it for every patient. "From an administrative point of view, it would be impossible to have different lists for different providers, and that is not what is required," she says.

If a patient cannot choose or will not choose, the discharge planner may steer him or her toward one or more providers, she says.

If the patient asks for help in choosing a post-discharge provider, it's permissible for discharge planners to take the opportunity to point out agencies affiliated with the hospital, she adds.

Discharge planners should not do as one individual Hogue observed and hand the patient the yellow pages.

"Discharge planners are professionals. Conditions of participation in Medicare and Medicaid require that they develop a discharge plan. They really do need to consult with the patients and assist them in choosing providers," she adds.

The list should include all providers who are Medicare- and Medicaid-certified that provide services in a geographic area where your patients reside and ask to be on the list, she adds.

Hogue recommends giving each patient the full list of providers, rather than trying to weed out those that don't provide the services the patient needs. "It's dangerous for case managers to try to eliminate agencies that can't meet the patients' needs. They often get it wrong."

For instance, a provider called one of Hogue's clients complaining his mother wanted home health care from the agency he owned, but the case manager told her they didn't provide the services.

"I recommend letting the patient choose and then contacting the facility to see if they can meet the patient's need. The services that these agencies provide change all the time," she adds.

Problems arise when the patient lives in a sparsely populated area where there are no home health agencies or skilled nursing facilities, Hogue points out. For instance, there are rural areas in Idaho and New Mexico where no home health services are available.

"That presents a real problem for families and discharge planners," she says. ■

Directory helps patients make informed choices

Hospital compiled information on all providers

When patients at Haywood Regional Medical Center in Clyde, NC, need post-discharge services, they can look for information about the providers they are considering in the hospital's Western North Carolina Provider Directory, a binder compiled by the case management staff and filled with information on home health services, skilled nursing facilities, and durable medical equipment providers.

"Even before it was a rule, we emphasized patient determination, giving patients the opportunity to choose their provider if they needed services after discharge," says **Shirley Trantham**, RN, BSN, CCM, director of health resource services, the case management department at the hospital.

Providers requesting inclusion on the hospital's list of post-discharge options fill out a provider questionnaire including pertinent information, such as what services they provide, what areas they serve, hours of service, information on Medicare and Medicaid certification, and other information patients will need to make informed choices.

In addition to the questionnaire, the binder includes fliers, brochures, and other promotional information the providers give the hospital.

The hospital keeps a copy of the binder on every unit and passes it from patient to patient when post-discharge services are needed. Patients receive a list of names and telephone numbers of providers and then have a chance to check out their choices using the directory.

When a patient is discharged to a skilled nursing facility, the case managers document that the patient made his or her own choice of facilities on the discharge planning record. Patients who choose a particular agency for home health service or durable medical equipment sign a self-determination form, indicating they made the choice.

Some patients already know the provider they want to use. Others spend a lot of time with the directory, checking out providers that can provide all the services they need.

"The directory makes it easy for patients to identify a provider that can meet their needs. If a patient needs more than one item or service, the

directory gives them the information they need to find a provider that can supply everything if that's what they prefer," Trantham explains.

For instance, some home care providers don't carry liquid oxygen because Centers for Medicare & Medicaid Services (CMS) reimbursement is the same whether oxygen is in liquid or gas form. Many patients want liquid oxygen because it is more portable and lasts longer.

When a patient chooses a provider, the case manager gets verbal permission from the patient to send his or her medical information to the agency to see if it can provide the services the patient needs.

If a skilled nursing facility has a bed available, the case manager makes sure the facility has all the information it needs to accept the patient.

"In our area, we have only a few skilled nursing facilities; and sometimes, the patient's first choice is full. Then, we come back and get them to choose another facility. Sometimes, we have to just put it out there to all of them so they can make their choice from what's available," she notes.

The case management staff encourage family members to visit the skilled nursing facilities and to check out the Medicare web site for each skilled nursing facility's quality of care data.

Sometimes, when the patient is not covered by Medicare or Medicaid, the hospital must indicate to its patients which providers are preferred providers for their particular health plan. North Carolina does not have managed Medicaid or managed Medicare plans.

"Sometimes, their choice is limited, and we tell them that they still can choose but their benefits pay as much and may cost them out of pocket," Trantham points out.

It's a challenge for discharge planners at Haywood when patients who are dual North Carolina and Florida residents need post-discharge services.

The area has a number of residents who spend their summers in North Carolina and winters in Florida.

If the patients are in a Medicare managed care plan in Florida, it's not always easy to find a provider that is a preferred provider for their health plan.

"We have a couple of national agencies that provide services in our area; and sometimes, we are able to get service through them. It does push out some of our small hometown companies," Trantham adds. ■

Medically complex cases present a challenge

System helps with those who are hard to place

Today's discharge planners face the challenge of finding post-acute services for patients who, thanks to improvement treatments and technology, survive more catastrophic illnesses and injuries than ever before.

However, many of these patients are medically stable and need to go to a lower level of care. Finding a facility that will take clinically complex patients often is difficult for hospital discharge planners.

"Discharge planning is extremely challenging for patients who have needs outside the typical cookie-cutter skilled nursing facility approach. What's left in the hospital are the acutely chronically ill with extraordinary discharge needs," says **Daryl Morgan**, LMSW, discharge planner at Atlanta's Crawford Long Hospital.

One of his most recent challenges was to find a nursing home placement for a paraplegic patient who weighed 700 pounds. The patient had a number of social and family issues that made it necessary for the hospital to pursue nursing home placement for him.

"The family insisted on something in metro Atlanta. For us, it was like pulling a needle out of a haystack," he adds.

In another case, after searching for two months, Morgan found a facility in Chicago that would take a ventilator-dependent patient only to have the patient's daughter make a last-minute request to transfer her father to a facility in Columbus, OH.

"Because of the inordinate amount of time we spend working on hard-to-place patients, we may keep other patients in the hospital inadvertently longer than necessary because of time constraints and human resources," Morgan explains.

Like most major medical centers, Crawford Long winds up with a large number of patients who have few, if any, financial resources.

"We start discharge planning when they come in the front door. We identify patients who are going to have post-discharge needs up front and start working with the families to see what resources are available," he says.

Morgan starts talking with the physicians early on to get a clear picture of the patients' prognoses and helps them apply for disability benefits if

they are expected to be permanently disabled.

The 700-pound man had some benefits, but because of his size, most facilities didn't feel they could manage his care. "Some facilities around town will take Medicaid patients or an occasional patient with limited resources. The trick is to find them, particularly facilities that will take people who are acutely ill and who have a high level of needs," he says.

The state of Georgia has few facilities that take weanable ventilator patients. That poses another challenge to discharge planners, Morgan adds. "Families always want their loved ones to be in a facility close to home, but it's extremely difficult to find a nursing home that accepts ventilator patients in the state of Georgia. People believe that if you're in an urban area, there's got to be a place for their family member, but that's not always the case."

Automated system was solution

Morgan found a solution to his problems finding placement for medically complex patients using the Extended Care Information Network (ECIN), an automated discharge planning and referral management program.

Unlike some other discharge planning software programs, ECIN allows hospitals to use its services on a case-by-case basis rather than signing a contract for long-term use.

Many hospitals with a lot of hard-to-place patients sign up for the service on a permanent basis, but others opt to use the service on an as-needed basis, says **Bill Keyes**, vice president for national accounts for the Chicago-based provider of web-based automated discharge planning and referral management software.

"It works very well. There's no commitment on the hospital's part, and the fee is less than a single day in the hospital. We found that after working with many hospitals around the country, some — either due to budget issues or other issues — don't have the financial resources to purchase a full system, but they still have many hard-to-place patients," he says.

Instead of faxing multiple pages to 15 or 20 providers, the case manager sends the information on the client who needs placing to ECIN and it's entered into a database.

"A hospital may have to spend 15 or 20 hours looking for providers. Our case manager enters the information into our system and within a day can contact hundreds of providers," Keyes says.

In compliance with Health Insurance Portability and Accountability Act regulations, the information does not have identifiable patient data. It contains diagnosis and needs. If the provider is interested in the patient, ECIN can provide more detailed information.

Having access to a large database of providers saves a lot of time and costs for hospitals, Keyes says. "Anytime patients leave the hospital, case managers or social workers are faxing information to multiple places."

Scripps Health, based in San Diego, did a time-and-motion study at one hospital before trying out the ECIN system, says **Mary E. Whitehead**, systemwide director for case management.

Before using ECIN, the hospital had a 1.3 hours response time from providers. Within the system, the figure dropped to 20 minutes, essentially saving an hour per referral, she says. "What we've seen is that the process of discharge planning is more thorough and efficient. We now can say that we have a 20-minute provider turnaround time and a 90% placement rate."

Scripps has different hospitals with different payer mixes and different operations models. Out of five hospitals, three use ECIN totally and do all discharge planning electronically, Whitehead says. "One of our biggest challenges is the process of communicating with providers regarding referrals. Every hospital in the system is different. In the past, most of them made phone calls, then faxed the information and waited for a response from the provider. It's a very time-consuming process for every case manager in every hospital to be calling all the providers in the area."

Before signing up with ECIN, the discharge planners provided patient criteria to skilled nursing facilities or home health and waited for a call back. The case manager then faxed the history and physical, progress notes, lists of medication, and pieces of the medical record. With ECIN, the process is completed electronically.

"The providers have to be able to read the information and decide whether they will take the patient based on the information they receive," Whitehead says. Some skilled nursing facilities have just one intake person, and it can take days for the discharge planner to get a return telephone call, she adds.

"What ECIN does is provide an electronic connection through the Internet so a case manager can send electronic referrals to a skilled nursing facility or home health agency with patient demographics and clinical information using

point-and-click technology," she adds.

The system saves time, cuts down on avoidable days, and helps free up beds for other patients, Whitehead explains.

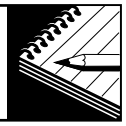
"There is a lot of emphasis on patient throughput within our hospital system. We are challenged every day to decrease length of stay and improve patient throughput," Whitehead says.

It's also a boon for discharge planners when a family member wants the patient to be transferred to a skilled nursing home facility in another state.

"Case managers can select a certain geographic location and find all the providers in that area," she adds.

The system allows the case manager to print a discharge package with information about post-acute choices, a feature that Morgan finds useful in helping families of difficult-to-place patients understand that the hospital has made every effort to find a facility near their home. ■

GUEST COLUMN



Certification helps CMs meet today's challenges

Skills, knowledge, competency enhanced

By **Hussein A. Tahan**, DNSc, RN, CNA
Chair
Commission for Case Manager Certification
Rolling Meadows, IL

Hospital-based case managers are facing mounting challenges today, from the aging of the population and the rise in chronic health conditions to the escalating cost of health care services and advancements in medical technologies. They are especially pressured to ensure that clients have access to cost-effective, appropriate, timely, safe, and efficient health care services. These demands are further compounded by the responsibilities placed upon them to be both advocates for patients and their families as well as stewards of health care resources.

In this complex and challenging environment, hospital-based case managers have at their disposal a powerful and effective means to distinguish themselves: certification. Certification allows case managers to demonstrate their educational background, experience, skills, knowledge, and competencies while executing their complex job responsibilities. As these pressures continue to exist in the future, certified hospital-based case managers will be even more valuable in the health care system for their ability to oversee patient care plans and assure they meet the desired patient and organizational goals.

The number of hospital-based case managers has been on the rise, a trend that is expected to continue, according to the Commission for Case Manager Certification (CCMC), the first and largest nationally accredited organization that certifies case managers. According to the 2004 CCMC Role & Function study, of the 6,300 case managers who responded to the survey, the largest percentage (18.8%) indicated they worked in a hospital setting. This was followed by 16.57% in independent case management companies, 14.55% in health insurance companies, and 14.5% in managed care companies.

As part of the 2004 study, the essential activities of case managers across all venues of practice were examined. These included assessment, planning, implementation, coordination, monitoring, evaluating, and outcomes, in addition to a "general" category related to functions applicable across all steps of the case management process, such as advocacy. The study also assessed knowledge areas necessary for effective and competent case management practice. These included case management principles and concepts, health care management and delivery, health care reimbursement, community resources and support, psychosocial/spiritual issues, and outcomes, as they relate to case management practice.

The CCMC's study also showed evidence of increased recognition of certification in case management by employers.

Specifically, 26% (1,585) of the case managers who participated in this study noted that the CCM credential was required at their facilities. In addition, 20% (1,268) of those who responded indicated there was a financial incentive given to those who attain CCM certification. These findings indicate employers are recognizing the value of certification in case management.

Certification allows case managers to access better job opportunities. Being certified indicates the achievement of an advanced level of competence in the practice of case management. That kind of competent practice is desired by all interested

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CRITICAL PATH NETWORK™

Self-determination form documents patient choices

Form includes information in triplicate

When patients leave St. Vincent's Medical Center in Jacksonville, FL, with referrals for post-discharge services, they take home a copy of the hospital's self-determination referral form, with information details about which providers they chose on the front and the list from which they made their choices on the back.

Another copy goes into the patient's medical record, and the third copy is retained by the case management department.

"It's basically simple. The social worker or case manager can talk to the patient and show them the back of the form. The patient makes a decision, and it's documented," says **Jamie Zachary**, LCSW, the hospital's director of care management.

The hospital goes beyond the Centers for Medicare & Medicaid Services requirements for giving patients post-discharge choices and gives all patients a choice about home health services, durable medical equipment companies, skilled nursing facilities, and ambulance companies.

The hospital's self-determination referral form is printed in triplicate. The front of the form, filled out by the care manager or social worker, identifies the resources to which the hospital made referrals and includes a statement at the bottom that the patient was given the list and given a choice.

The form is signed by the patient and by the staff member. The back of the form contains a list of all providers who requested to be on the list and identifies those that are Medicare certified with asterisks and those in which the hospital has a financial interest in boldface type. **(See form, pp. 24-25.)**

"Patients find it helpful to have this information when they get home, particularly if the durable medical equipment company or home health agency doesn't show up as expected. They have the name and telephone number of the provider handy and don't have to call the hospital for help," Zachary explains.

As soon they know a patient will need post-discharge services, the care manager or social worker presents him or her with the list of providers. In the case of patients who can't decide on a facility or who don't want to choose, the staff rotate through the agencies on the list.

The discharge planning staff are familiar with the companies and what services they provide and work with the patient to help them choose.

"Giving an elderly patient a list of 30 companies is daunting to that patient," Zachary adds. "If the patient needs a particular service and we know only four companies provide it, the staff points out these four and helps the patient narrow it down."

The hospital notifies patients as to which agencies are preferred providers for their health plan, and, in most cases, that is the provider the patient will choose. When physicians write an order for a specific company, the care manager or social worker explains that the patient has the option of considering other providers. Most patients go with the physician's choice, but the hospital has documented that they know they have an option, she points out.

The hospital encourages family members to check out skilled nursing facilities as early as possible, dropping in on the facility, talking with the administration, and taking a tour.

Whenever possible, the care managers and social workers ask patients and family members

(Continued on page 26)

ST. VINCENT'S
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DISCHARGE INFORMATION
PATIENT CHOICE FORM

☐ **Transportation Company:**	Phone:
Type of Transport/Time:	Payment Source:

☐ **Home Health Agency:**	Phone:
Contact Person:	Payment Source:
Services:	

☐ **Durable Medical Equipment Company:**	Phone:
Contact Person:	Payment Source:
Equipment/Delivery:	

☐ **Facility Placement:**	Phone:
Contact Person:	Payment Source:
☐ Skilled ☐ Intermediate	

☐ **Community Referrals:**	
1)	Phone:
2)	Phone:
3)	Phone:

Discharge options have been discussed with me. I have received a list of some providers in my community. Providing this information does not constitute an endorsement by St. Vincent's Health System (SVHS) of any provider. Based on this list, I choose to receive services from the companies above.

I understand SVHS cannot ensure payment by my insurance company to the provider(s) whether or not the provider(s) is approved by my insurance company. I also understand that I may choose a provider which is not an authorized provider by my insurance. In either event, the cost for the service will be my responsibility.

I authorize SVHS staff to furnish information requested by any of the above companies including a verbal referral and/or a copy of my medical record. The release of information regarding psychiatric, drug and alcohol treatment is authorized. The release of information regarding AIDS, Human Immunodeficiency Virus infection, and the performance of any tests or counseling and the results and treatment thereof is also authorized.

Staff Signature **Date** **Patient and/or Family Signature**

HOME HEALTH

NAME		PHONE
AHP Home Health Care[M]		766-1285
AmeriCare Home Therapy[M]		722-1515
American Elder Care – Medicare only		724-5600
Apex Healthcare Solutions		425-4202
Arcadia		731-1183
Atkinson's Home Care[M]		269-8050
Atlantic Home Care[M]		448-5353
ATS Health Services		398-9098
Baptist Home Health Care[M]		202-4400
Baycare[M]		296-0605
Coastal Health Services		419-4904
Community Hospice[M]		268-5200
Coram Home Health[M]		363-3089
Florida First Care [M]		269-6868
Gentiva[M]		731-3515
Home Care Advantage[M]		306-9729
Home Companion[M]		332-1000
Hospice of Jacksonville [M]		733-9818
Housecall[M]		296-0815
Interim Health Care		448-1133
Life Care Solutions		399-1170
Matria		278-7275
Maxim Health Care		721-8333
Medi Home Health		998-4408
Metabolic Consultants, Inc.[M]	(813)	298-0404
North Florida Health Services [M]		241-1656
Nurse Finders[M]		399-8021
Nurses As Needed (private only)		733-4100
Omni Home Care[M]		519-9233
Option Care[M]	(800)	248-1820
Patient Care [M]		477-7023
Senior Home Care		730-4640
Shands Home Care[M]		244-9900
Sunbeam Healthcare Services		762-1528
Suwannee Home Care		384-3394
Tehc		722-1112
Tender Loving Care[M]		354-4425
Total Patient Care[M]		399-1142
Underhill Home Care		396-7553
Welcome Home Care[M]		727-9624
Well-Done Home Care[M]		693-4516

EQUIPMENT/INFUSION

NAME		PHONE
Advanced Home Respiratory Care[M]		276-7731
American Home Patient [M]		448-3899
Apria Healthcare[M]		363-3200
ASAP Home Respiratory [M]		448-5757
Atkinson's[M]		269-8050
Capital Medical Corporation		759-3496
Carter's/Park & King [M]		389-6601
Consolidated Pavilion Infusion Care		202-5730
Coram Home Infusion[M]		363-3089
Desloge Home Oxyg. & Equip.		396-0237
D.L.T.		448-4601
Elite HomeCare, Inc.[M]		306-1864
Family Focus (Infusion Only)[M]		855-0040
First Coast Medical[M]		276-7696
Fletcher Medical Supplies[M]		387-4481
Hall-Moore Medical[M]		731-7212
Home Care Supply[M]		781-4448
Jc Home Medical (respiratory equip.)		448-9827
Life Care Solutions[M]		399-1170
Lincare[M]		288-8188
Medequip[M]		246-0333
Med-Equip Solutions[M]		726-0210
Medco Inc.[M]		264-8154
Medi Home Health Infusion/equip		998-4408
Metabolic Consultants, Inc.[M]	(813)	298-0404
PRN[M]		731-7880
Preston Pharmacy[M]		725-1616
Regenesis Health Services, Inc. [M]		262-0340
Rotech[M]		448-5353
Sterling Medical Services		1-888-202-5700
VitalAire[M]		680-2300
Wheelchairs Plus[M]		779-5603

MEDICAL TRANSPORTATION

Advanced Patient Transportation[M]	**278-8811**
Ambulance Service, Inc.[M]	733-6600
Century Ambulance & Wheelchair Svc[M]	356-2828
Liberty Ambulance & Wheelchair Svc[M]	721-0008

SKILLED NURSING FACILITIES

NAME		PHONE
St. Catherine Laboure' Manor		**308-4700**
All Saints[M]		772-1220
Avante Villa (Jax Beach)[M]		249-7421
Atrium Health Center[M]		724-4001
Beauclerc Manor[M]		739-0877
Bradford Terrace (Starke)[M]		964-6220
Brooks Rehab Ctr[M]		858-7600
Cathedral Convalescent[M]		798-5300
Cedar Hills[M]		786-7331
Cypress Village Health Care Ctr[M]		223-6100
Doctors Lake Healthcare (OP)[M]		269-2610
First Coast[M]		725-8044
Fleet Landing[M]		246-9900
Frank Wells (Macclenny)[M]		259-6168
Governor's Creek		284-5606
Harts Harbor[M]		751-1834
Hearland of South Jax[M]		733-7440
Heartland (Jax)[M]		783-3749
Heartland (OP)[M]		264-3912
Home Quality Management		272-6194
Edgewood Nursing Home [M]		766-7436
Lakeside Nursing & Rehab Home		714-3793
Lanier Manor[M]		757-0600
Life Care Center (Hilliard)[M]		845-3988
Life Care Center Wells (OP)[M]		264-1950
Life Care Center (OP)[M]		272-2424
Macclenny Nursing & Rehab Center[M]		259-4873
Jacksonville Nursing & Rehab Ctr.[M]		766-2297
Palm Garden[M]		733-6954
Park Ridge (Jax Con)[M]		358-6711
Regents Park[M]		642-7300
River Garden[M]		260-1818
Riverwood[M]		721-0088
South Lake[M]		268-4953
Southpoint Terrace		245-7620
Summer Brook Health Care[M]		768-1506
Supbridge - Southside[M]		724-5933
Suwannee Health Care Ctr. [M]	(386)	362-7860
Tandem Healthcare (Jax) [M]		296-6800
Tandem Healthcare (OP)[M]		269-8922
Taylor Care Ctr.[M]		731-8230
Taylor Home [M]		737-6777
Vicars Landing		285-1055
West Jacksonville Health & Rehab [M]		786-8668
Westminster Woods[M]		287-7300
Windsor Manor/Starke [M]	(904)	964-3383

Bold *Italic* Denotes affiliation with SVHS

Resources out of the Northeast Florida area available upon request.

M Denotes Medicare certification

(Continued from page 23)

to select more than one facility and to authorize that patients' personal identifiable medical information be sent to several facilities to ensure the hospital can find an available bed.

"A lot of times, the family will consider only skilled nursing facilities within a few miles of their home. That narrows it down. We tell them which ones they are and encourage them to visit," she says.

The hospital has a significant number of patients who do not live in the greater Jacksonville area, many of whom are cardiac patients from South Georgia.

The list includes a statement that says that resources out of the area are available. The cardiac care management staff has a list of facilities and agencies in South Georgia and provides that list to patients from that area. ■

Care costs, demand increased in 2003

Demand for inpatient and outpatient care continued to grow in 2003, as did the costs of providing that care, according to the latest American Hospital Association (AHA) Annual Survey.

Hospital expenses per adjusted admission grew by 6%, driven by the rising costs of new technologies, pharmaceuticals, and payroll, the survey found, but reimbursements failed to keep pace, causing operating margins to decline.

Medicare payment fell to 95 cents for every dollar hospitals spent caring for Medicare patients, and Medicaid reimbursement fell to 92 cents on the dollar. As a result, hospitals' financial health remained fragile, with roughly one-third operating in the red. Even as overall demand for care increased, hospitals experienced a 1.1% decline in outpatient surgeries — the first in more than two decades — reflecting the rapid growth of ambulatory surgery centers.

The survey results were released in *AHA Hospital Statistics 2005,* published by the AHA subsidiary Health Forum. ▼

AHRQ tool offers help to assess hospital safety

The Agency for Healthcare Research and Quality has unveiled a new tool to help hospitals evaluate their progress in creating a culture of safety. The Hospital Survey on Patient Safety Culture helps hospitals assess employees' attitudes about patient safety, teamwork within and across units, openness of communication, response to errors, and other key components of a safety culture.

The American Hospital Association (AHA) will encourage members to use the survey to obtain a more complete picture of the quality of care they provide and identify opportunities, according to **Nancy Foster**, AHA senior associate director for public policy development. "Creating an organizational culture in which staff are aware of the critical role they can play in patient safety is fundamental to patient safety improvement."

Paul Schyve, MD, senior vice president of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), said conducting the survey would help hospitals meet JCAHO accreditation requirements. For a survey and user's guide, go to www.ahrq.gov/qual/hospculture. ▼

CMS releases paper on HIPAA security rule

The Centers for Medicare & Medicaid Services (CMS) has released the first in a series of seven papers intended to give guidance on the Health Insurance Portability and Accountability Act's (HIPAA) security rule. Each paper will focus on a specific topic related to the "Security Standards for the Protection of Electronic Protected Health Information," commonly known as the security rule. Most hospitals and health plans must comply with the rule by April 20, 2005.

The first paper provides background on the rule and its relationship to the HIPAA medical privacy rule. Future papers will address administrative, physical, and technical safeguards; organizational policies and procedures and documentation requirements; basics of risk analysis and risk management; and implementation for small providers.

To see the final security rule, go to the CMS web site at www.cms.hhs.gov/hipaa/hipaa2. ■

ACCESS MANAGEMENT
QUARTERLY

System addresses ability to transition in emergencies

Tool for disaster preparedness, ED overcrowding

A scoring system for assessing which patients are most ready to be discharged from the hospital can be an important emergency preparedness tool, suggests **Pat Orchard**, CCM, CHE, director of health services for Horizon Blue Cross Blue Shield of New Jersey, based in Mount Laurel.

"It's a methodology for tracking acuity," says Orchard, who has worked as a case manager in a variety of settings. "A lot of organizations have acuity systems but use them for determining nursing staffing ratios — [a defined number of] acute patients to a nurse."

The same concept, she points out, can be extremely valuable when used to determine a patient's readiness to be transferred to the next level of care. Hospitals that categorize patients in some format indicating "readiness to transition," Orchard adds, can move quickly and efficiently in the event of disaster or even ED overcrowding.

"When you're talking about capacity, what comes in must go out," she notes. "The balance has to be there. If not, there's a tremendous amount of delay."

Typically, organizations focus on input — getting ED patients into treatment rooms and then to the nursing floor, for example, Orchard says. "But if you don't address output, managing patients to move them out efficiently and effectively, you don't solve the throughput problem," she points out.

Without a system for categorizing patients, she explains, hospital staff faced with high-capacity moments may spend hours trying to free up beds.

"Say, for example, you had to move 40 people out of the hospital because there was a disaster in the community," Orchard adds. "Nurses are [examining] every patient in the hospital to determine readiness [to move]. Everyone is running in circles trying to find beds."

If a scoring system is in place, however, the patients who are most ready for discharge already will have been identified, and — after physician orders are obtained — can be moved quickly and easily, she says.

Step 1: Establish criteria for acuity levels

The first step in implementing such a system is to establish criteria for acuity levels and categorize patients based on those criteria, Orchard advises.

"You can use numbers, or letters, or any kind of scoring you want, but you are scoring the patient based on readiness," she adds.

Whether the scoring grid is based on 1 to 4, 1 to 3, or something else, the information can be put into the computer system and pulled out in a report when needed, she says.

"If you're using a score of 1 to 4, those patients who are leaving in the morning, waiting for nursing home placement, or finishing one more course of treatment may be 4s. This is a basic acuity system, but it's based, not on clinical findings, but on the transition capability of the patient," Orchard explains.

"How quickly can they transition to the next level of care?" she asks.

These are patients about whom physicians say, "Maybe they can go tomorrow, or maybe they should stay one more day," Orchard adds. "Some physicians don't move patients as fast as they could."

From a managed care perspective, she says, some might question why such patients still are in the hospital if they can be discharged safely. But the fact is, they *are* there, she continues.

"Maybe the physician hasn't been in yet, or the physician was in that morning and test results weren't back then. Multiple inefficiencies are out there," Orchard notes.

Once a scoring system is in place, she adds, "at least you know where to focus your attention."

"Have a set of parameters," Orchard suggests, "so that when you do get in a crunch, you're able to turn quickly to the high-level patients who can be moved out immediately. Make sure physicians have agreed to the process and to the scoring system the hospital has developed."

Whether the physician must be called when the process is put in motion — as the result of a crowded ED or a natural disaster — depends on the policies of the organization, she says. "Most would call to get the discharge order."

Assessing and scoring of patients should be done daily or even twice a day, depending on the hospital census, Orchard recommends.

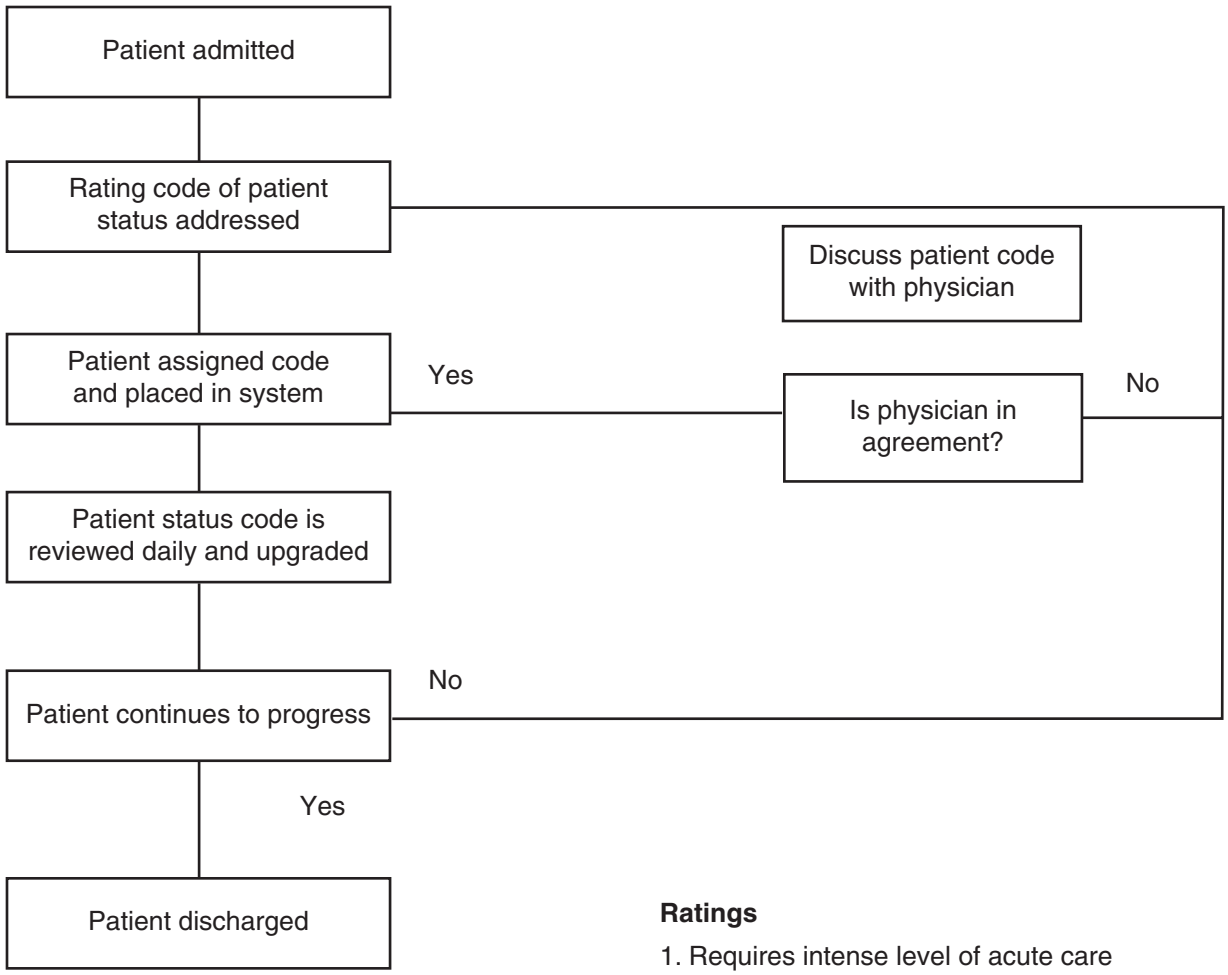
"If done in conjunction with nursing or case management rounds," she adds, "the time required should be minimal."

System came out of 9/11 response

Virtua Memorial Hospital of Burlington County in Mount Holly, NJ, was one of the facilities that got a call on Sept. 11, 2001, asking staff to find room for a possible deluge of patients seriously injured in the attack on the World Trade Center, says **Dee Page**, RN, director of case management.

"We were one of those hospitals in the Northeast that were in close enough proximity that we

Patient Readiness Ratings



Ratings

1. Requires intense level of acute care
2. Requires significant level of care
3. Requires acute care but is progressing
4. Minimal acute care needed; discharge planned

Source: Virtua Health, Mount Holly, NJ.

thought we would have an influx of patients," she explains. "On Sept. 11, we got a call about 10 a.m. and were told to be ready. At that time, it was thought that we would have a lot of sick and injured patients," Page continues.

By 11:30 a.m., the hospital had emptied 62 beds in preparation for the expected patients, but unfortunately, most of the victims turned out to be casualties, and the beds weren't needed after all, she adds.

The quick and the dirty

That experience, however, led to the development of a quick and dirty way to determine which patients could be moved on a daily basis, she says, not only in the event of an emergency, but to address throughput.

The case management department established a scale of 1 to 4, with 4 being the lowest acuity rating, "the patient closest to the door," for whom there is a discharge plan in place, and 1 indicating an intense level of acute care, Page says. Next are the 2s, who require a significant level of care — patients in a step-down unit or maybe telemetry.

The level 3 patients require acute care but are progressing, she continues. "These may be post-operative patients, or those who are being treated aggressively and showing improvement, but who are not primed enough to go to a skilled nursing facility."

"There could be a fifth tier," Page notes, "a shaded area that would more or less indicate a patient who is being observed. If you wanted to push the envelope, you could add this level."

A departmental flowchart shows each patient and the rating code for the person's status. **(See "Patient Readiness Ratings," p. 28.)** The patient's readiness level is determined at admission and reassessed daily, she says.

The readiness rating also is entered into a web-based system that includes utilization review and discharge planning information, Page adds. "Pieces of that documentation are printed and placed in the chart, and the rest lives in the system as a lifetime record."

That system is helpful at the time of discharge, she says, because it documents where patients are sent or referred.

"Where we fall short [with the patient readiness rating] is that nursing does not use it with us," Page points out. "The nursing department has not decided to go along with this," she says.

The nursing department had a readiness project of its own — a color-coded system that was tied to staffing ratios as well as patient acuity," says Page.

"What that meant to them was that, if census and acuity go below certain levels, the staffing is adjusted. As soon as they see the coding, they know they need extra staffing or that there are empty beds.

"The [nursing project] never got off the ground, but we continue to use our system," Page adds. "We know at any time how many beds are occupied by a particular type of patient."

In addition to its value during times of overcrowding or crisis, she notes, the patient readiness score helps caregivers prioritize the workload, if a case manager is not there, and take a more proactive role in assisting physicians with discharge decisions.

"In our documentation system, we have an RC [review case] due date," Page explains. "For instance, if you have a managed care patient, and have just done a review with the payer, and the payer authorizes a three-day stay, technically, you wouldn't have to look at [that case] for three days."

System helps prioritize

While that system helps in managing caseloads, she points out, "the readiness rating goes beyond the obligation to see the patient again." There might be six patients on the case manager's list who require acute care and are progressing, Page adds, but the readiness check could reveal that one of those patients is now a 4.

The case manager then can suggest to the physician that the patient might be ready for an earlier discharge, she says. "So it helps them further prioritize — it's very valuable in that respect.

"It used to be that if you knew you were being paid for three days, you left it alone, but we really don't feel that way anymore," Page points out.

"It's better to have your beds filled with people who are really sick. It's better for the patient if you can move beds sooner."

With abdominal surgeries, insurance companies often authorize lengthy stays, and patients may be ready for rehab or discharge sooner, she adds. "The theory of 'Fill your beds; fill your beds' doesn't work anymore."

In terms of the readiness scoring system, the focus of the case manager's day is with the 2s and 3s, Page says.

"With 2s, you want to make sure you can move them through the system to a more appropriate bed, or ask, 'Have they finished that course of treatment? Do they need to be transferred to another facility?'"

With 3s, she adds, the idea is to make sure they are not the next patients to be designated as 4s. With 4s, the discharge plan is complete and just needs to be activated, Page notes. "If someone was told yesterday that [he or she] could move to rehab today, that patient would have been a 4 yesterday."

System not labor-intensive

When the time comes to empty some beds quickly, case management — the only department using the patient readiness system — gets the first call from one of Virtua Memorial's bed-flow coordinators, she says.

"We often go on divert here — beds are full, and we have to send patients elsewhere — and [the coordinator] comes to us right away, asking, 'What can we do to open some beds?'"

When that call comes, Page says, "We go right to the 4s and make some calls to physicians to let them know there is a crunch. Sometimes, they say they're in the hospital and will be up to discharge the patient. They almost always want to see the patient."

With elderly patients who will be transferred to nursing homes, she notes, the case managers often will have gotten a heads-up that, for example, the patient still is receiving treatment, but this will be the last day. In those cases, Page adds, the discharge might be all sealed up for a particular date.

Although the readiness system is an internal mechanism for the case management department at present, Page says she would like to see it fully implemented at all the Virtua Health campuses.

"It's not labor-intensive at all," she notes.

"It's putting a sticker on the chart. On those days when we're short-staffed, or even when we're full and somebody wants to organize the day, it helps to have [the rating].

"Instead of relying on a whole lot of other people for information, the case managers can look at the scale and see what they have, and know which patient to address first," Page adds.

[Editor's note: Pat Orchard can be reached at patpj@att.net. Dee Page can be reached at (609) 267-0700.] ■

CE *questions*

Note: Question 4 replaces the last question from the January 2005 issue, which referred to information not contained in the issue.

4. The pediatric asthma case management team at Hurley Medical Center in Flint, MI, consists of Jan Roberts, RNC-AEC, pediatric asthma 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
5. Penalties for failing to give patients a choice of post-discharge options include loss of Medicare and Medicaid certification.
   A. true
   B. false
6. The Western North Carolina Provider Directory produced by Haywood Medical Center includes which kinds of information:
   A. brochures
   B. fliers and promotional materials
   C. an information form filled out by providers
   D. all of the above
7. Among case managers replying to the CCMC's Role and Function Study, what percentage of case managers work in a hospital setting?
   A. 10%
   B. 13.6%
   C. 25.5%
   D. 18.8%
8. The self-determination form at St. Vincent's Medical Center in Jacksonville, FL, includes information on which post-discharge options?
   A. home health agencies and skilled nursing facilities
   B. home health agencies, skilled nursing facilities, and ambulance services
   C. home health agencies, skilled nursing facilities, DME providers, and ambulance services
   D. home health agencies, skilled nursing facilities, DME providers, and private duty nurses

Answer key: 4. A; 5. A; 6. D; 7. D; 8. C

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a certificate of completion. ■

(Continued from page 22)

parties: patients, providers, health care executives, and payers. Furthermore, there are indications in the market of a rising number of employers who value case management certification.

This is evidenced by the current trend of advertisements for case management jobs that ask for certification in case management as either a required or preferred condition for employment in addition to experience.

Case managers, including those in hospitals and acute-care settings, prefer to work in environments in which their competence, educational degree, type of certification, and contributions to patient care and organizational outcomes are valued, recognized, and rewarded through financial compensation or career advancement. There is evidence in the recruitment market that employers are willing to provide more financial compensation to case managers who are certified.

In addition, many hospitals have career ladders that underscore the value of certification as part of professional development and career advancement.

The CCMC is the largest and oldest case management certifying body accredited by the National Commission for Certifying Agencies (NCCA). Of the 100,000 case managers in the United States, approximately 26,000 hold the CCMC's Certified Case Manager (CCM) credential. Recognizing changes in the case management field, the CCMC has broadened its certification eligibility criteria to include case managers working in a variety of venues, especially those in hospitals and acute-care settings.

The new criteria, made effective with the October 2002 exam, include those listed below:

1. Eliminating the requirement that case managers apply the core components of case management in "multiple environments." The new standard defines the continuum of care as matching the needs of the individuals being served with the appropriate level and type of health, medical, financial, legal, and psychosocial care and services within a setting or across multiple settings.
2. The case manager's primary focus being on case management practice. CCMC recognizes that although case managers focus primarily on the provision of case management services, they may be involved in direct care activities such as "complex patient education regarding health regimen."
3. Waiving the requirement that applicants for the CCMC exam have an approved license awarded on the basis of an examination. This allows social workers and other allied health care professionals, whose states do not require an exam for licensure, to sit for the CCM exam.

Clearly, under the new criteria, hospital-based case managers are eligible to sit for the CCM certification exam. More information about the case management certification is available at the CCMC web site at www.ccmcertification.org.

Along with a growing demand for and recognition of certification for individual case managers, there also is an increased trend in the certification of organizations, such as acute-care hospitals.

Lately, confusion has arisen regarding individual and institutional certification in case management.

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There are distinct differences, however, between a certification of an individual vs. an organization.

Certification for an individual takes place in the form of a credential usually based on passing an exam. However, certification for an organization or program within an organization is offered in the form of an accreditation based on demonstrating compliance with specific national standards.

Health care professionals, and in particular hospital-based case managers, must be aware of these important differences and communicate them carefully with members of the public and others.

Perhaps the most important difference, particularly for patients and other members of the public, is that the certified individual is a professional who has achieved an advanced level of competence in an area of specialty or practice such as case management. The certification of a program, service, or specialty at an institution shows that it is recognized as a "center of excellence" in this particular area.

When a facility such as a hospital is accredited, the certification does not automatically extend to the individual professionals working there.

Similarly, having certified professionals on staff does not allow a facility to claim certification. If a hospital is accredited by an appropriate agency and employs certified case managers, it demonstrates a meaningful commitment to excellence in care.

The field of case management already has undergone tremendous change and will continue to evolve and mature. As the CCMC evaluates the results of its 2004 Role and Function study, it will be closely monitoring changes in the field, especially as they occur.

For example, the job of a case manager likely will include demands to decrease costs, allocate resources, utilize techniques such as disease management, and emphasize patient and organizational outcomes.

The CCMC's study of the field also enables the commission to ensure its certification exam remains evidence-based, backed by scientifically conducted research, and reflective of the current demands and practices of the field.

Keeping the certification exam up-to-date and relevant is essential to assure certified professionals can demonstrate their knowledge, expertise, and competence in case management.

Moreover, through certification, case management professionals will be distinguished in the field. Certification is vital for hospital-based case managers who face the dual pressures of advocating for patients and their families while allocating resources in an acute-care setting.

Hussein A. Tahan, DNSc, RN, CNA, is the chair of the CCMC, the first and largest case management certifying organization to be accredited by the NCCA.

He also is the director of nursing for Cardiovascular Services and Care Coordination at Columbia University Medical Center, NewYork-Presbyterian Hospital in New York City.

Additionally, Tahan is the co-author of The Case Manager's Survival Guide: Winning Strategies for Clinical Practice. ■

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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. ■