HOSPITAL CASE MANAGEMENT™

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Computerized case management: What technology can do for you

Electronic records are vital for case managers, some experts say

If your case management department isn't replacing paper records with electronic technology, it's likely to become more difficult to find the information you need to cut down on avoidable days and denials, track outcomes information, and demonstrate the value of case management to your hospital's administration team.

"To be effective in their role, case managers must have ready access to clinical and administrative records. The information needs of case managers won't be met if they rely solely on paper-based records," says **Patrice L. Spath**, BA, RHIT, a health care quality specialist with Brown-Spath & Associates, based in Forest Grove, OR.

A 1993 report by the General Accounting Office estimated that more than 10 billion pages of patient records are produced annually in the United States. That's a lot of paper to plow through as you go about your day-to-day operations.

Computerized case management systems put all the information from multiple filing cabinets and desk drawers into one place where it can be accessed with a few keystrokes.

"Information technology can provide case managers with better information about the payers, enabling them to recommend more efficient services more quickly and help avoid unnecessary and sometimes costly delays in patient care," Spath says.

Computerization also helps case managers transmit their recommendations to the right people at the right time, ensuring that caregivers can put the information into action in ways that will improve the overall quality of patient care, she adds.

Information technology allows case management directors to quickly generate reports that are almost impossible to compile with a paper system, such as length of stay by DRG and attending physician, quality measures being tracked, case manager productivity tracking, avoidable days, and

readmissions, says **Rodd Padden**, MBA, vice president of business development for Canopy Systems, a provider of web-based case management solutions, now part of A4 Health Systems in Cary, NC.

Technology systems for case managers offer significant opportunities to improve your hospital's bottom line — and a way to prove it. Now, instead of pulling out paper files and punching the information into a spreadsheet program, case management directors simply have to push a few buttons and print out a report.

"Technology is the right solution for case management. It allows us to do so many things we couldn't do with paper records. I can look at length of stay and denials in a myriad of ways and create a report quickly instead of having to wait for the data. It's empowering. The staff are absolutely empowered with data," says **Mary Barrington**, RN, MBA, assistant director for patient resource management at Duke University Hospital in Durham, NC.

Barrington and her staff of 50 patient resource managers went live with an automated case management system from Canopy Systems July 1, 2004.

"Case managers who have automated case management solutions can help ensure the plan of care is being followed and that all the needs of patients are being met in a timely manner. This helps reduce avoidable days and excess days," Padden adds.

Denials often result from poor workflow processes and poor communications, he notes.

With an electronic system, case managers can log on and access their own work list, getting real-time information about patients who have been admitted or moved from one floor to another.

For instance, if case managers perform a clinical review on every patient, each case manager is alerted when patients to whom they are assigned are admitted. They also are alerted when they need to perform additional reviews and when they need to communicate the review to the payer.

"This streamlines the workflow and improves overall productivity. The automated process improves communications with the payers and helps the hospital avoid unnecessary denials," Padden says.

But despite all the evidence of time savings and cost savings that result from computerized systems, at many hospitals and health systems, the case management, utilization, and discharge planning departments still are documenting manually.

"About 70% of hospitals are still in the kind of environment that means when they perform a clinical review to get authorization to treat a patient, they use a one-page form and fax that page to get authorization," Padden says.

On a case-by-case basis, paper records are probably fine, Spath says.

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"Case managers make a few notes on Day 1 and more on Day 3 and file their paper records for discharge date so they can pull them out later. Paper is fine for that function," Spath says.

On the other hand, she points out, case managers are being asked to compile reports from data that must be aggregated for numerous records. That's where a computerized information system can save case managers hours of work.

Hospital management is starting to view case management as a strategic area to improve the financial performance of the hospital as well as the quality of care that is being delivered, Padden adds.

"The impact that automating case management would have to the bottom line typically is the driving factor of anybody investing in case management technology," he says.

The majority of Canopy Systems clients see a return on investment within a year, depending on their case management model and how computer-savvy the staff are, Padden adds.

Implementation can take as little as a few weeks, but three months is more typical. It probably will take at least six to nine months or longer before everyone on your team is up to snuff.

When you implement an automated case management system, be prepared for resistance and a long learning curve for your staff, Barrington advises.

"Nurses and social workers are not in fields that have demanded strong technical skills. It will take time to get them up and running on the system," Barrington says.

Be patient as staff adjust to the new system. Allow a sufficient amount of time for change to occur and become habitual, she adds. "We're not 10 months into the new system, and the naysayers are coming around. Now they understand why I asked them to do certain things in the beginning, because it makes them more proficient now."

The downside of a high-tech case management system is, in some cases, highly skilled case managers spend a good portion of the day inputting information, Spath says. "In some cases, it seems like the goal of people with electronic case management systems becomes to fill up the required data fields, with the idea that it can be accessed later, if it's needed. This means that case managers spend 25% of their time inputting information that isn't necessarily needed," she adds.

Don't rush into purchasing an expensive technology system without spending a lot of time determining your needs, Spath advises.

"I'm not necessarily a proponent of computerization if case managers don't have a need for a lot of aggregated information or if it is already available in some other hospital system," Spath says.

Start by asking yourself what you are going to do with the information you write down on paper. If all you're going to use it for is as backup if someone in a health plan asks for more documentation, you might not need a computerized case management system, she points out.

On the other hand, if you have to gather information to create aggregate reports, such as analyzing avoidable days and the cause of them, it's helpful to computerize these data elements to make it easier to create the report.

Don't rush into spending a lot of money for information technology dedicated to case management without finding what already may be available in your hospital, Spath advises.

"It may be more efficient for case managers to get 10 data fields on the hospital's clinical claims system and input their data into those data fields than to go out and purchase a whole case management system," she says. ■

Ensure your system meets current and future needs

Involve stakeholders in planning, implementation

When you choose an information system for your case management department, make sure it will meet your future needs, as well as your current needs, advises **Vicky Mahn-DiNicola,** RN, MS, CPHQ, vice president for clinical design support services at ACS Healthcare Solutions, Midas+ with headquarters in Tucson, AZ.

"An information system represents a sizeable investment, many weeks of implementation, and often involves a comprehensive training process," she says. "To ensure a return on their investment, case managers should plan further downstream, looking at what their needs are likely to be like in three to five years in additional to what they are doing now."

Before starting the process of evaluating candidate systems, clearly define what your case management model is today, what functions you perform, and how your case management program

aligns with your hospital's short-term and long-term goals, Mahn-DiNicola advises.

For instance, today you may be doing discharge planning and utilization review, but it may be possible that in the future, the case management role will evolve to include outcomes management responsibilities or integrate with other departments such as quality management, risk management, or patient care services, she points out.

"People are realizing that case management is about managing a particular population of patients and tracking whether they're making things better or worse, looking at opportunities to improve processes of care, ensuring delivery of evidence-based practices to maximize efficiency. That starts to integrate the case management role with quality and performance data and puts a whole new light on the kind of case management software you need," Mahn-DiNicola says.

Case management directors should make sure their hospital administration understands the benefits of case management and how automating the case management process will affect the bottom line and the quality of care being delivered, adds **Rodd Padden**, MBA, vice president of business development for Canopy Systems, a provider of web-based case management solutions, which is now part of A4 Health Systems in Cary, NC.

The most successful implementations of automated case management systems occur when the hospital's information technology and case management departments collaborate on the choice and implementation of the system, Mahn-DiNicola says.

"Where I see problems is when the information technology department leads the search for case management systems and serves as the principal owner. If the people in information technology don't really have a clear vision of what case managers do, they will look for a technical solution to the strategic goals of the IT world but not the long-term needs of a clinical department," she adds.

All hospitals are different, with different case management models, a different set of problems to solve, and different information needs, says **Patrice L. Spath**, BA, RHIT, a health care quality specialist with Brown-Spath & Associates, based in Forest Grove, OR.

Before you start looking for a system, think about what problems or issues you are trying to solve and determine what data you need to get out of your system, then evaluate the case management system on its ability to help you do the job, she advises.

For instance, there may be delays in referrals for case management, or the case manager doesn't know a patient was admitted from the emergency department (ED) overnight and doesn't see him or her until later in the day, Mahn-DiNicola says.

Evaluate each system you are considering as to how likely it is to improve your case management referrals and your case identification. Evaluate the software as to how it is likely to improve your case identification.

Patients who fall through the cracks

Patients who fall through the cracks may be another problem in your hospital. For instance, you may want to track pediatric patients who are readmitted with asthma but also track those who were treated in the ED and released. You may want to know who your sickest patients and highest utilizers are. In that case, look for a system that supports rules-based processing so you can customize it to identify the patient population within your organization that require case management interventions, Mahn-DiNicola says.

List everything you need for each case management function you perform. For instance, for a patient assessment, you'll need the patient's past history, demographic information, occupational history, past illnesses and surgeries, social and family history, and current health status.

"A computerized information system should assist case managers in making decisions about patient care requirements and expected resource use, and allow for monitoring of the results of care planning choices," Spath adds.

As you plan your software system, keep in mind the four major functions of case management: assessing your patient's health care needs, developing an effective plan of care, arranging for and coordinating needed services, and evaluating the effectiveness of the plan of care.

Avoid a software product that does not appear to include the "must-have" features that allow for assessment, planning, implementation, and evaluation, Spath says.

Keep in mind that if you adopt a stand-alone case management system that doesn't integrate with other information systems in your hospitals, such as finance, cost accounting, risk management, or quality, you will create an information silo, which won't serve the hospital well in the long run, Mahn-DiNicola points out.

For instance, the case management department may run one report on heart failure readmission

rates, while the quality department and the finance department may run the same kind of reports using their software system, and arrive at three different readmission rates.

"All systems can define something as basic as a readmission rate, but they all have different values because the criteria to construct the measure is different. This type of data schizophrenia not only jeopardizes the credibility of the data generated by the case management department, but it also requires extensive time and expertise to explain the data reported by the various systems," Mahn-DiNicola says.

To avoid this, it is helpful to consider all the information stakeholders during the selection process in addition to the functional users who will use the software for daily case management operations, she adds.

Case management software should be plugged into the large hospital information system infrastructure so all of the information can be integrated.

For example, the risk management department tracks medication errors and patient falls, the infection control department tracks surgical infections, and the patient advocate tracks patient complaints. Case management can leverage those types of information to create triggers so when patients are admitted with a history of MRSA, previous falls, or a prior complaint about nursing care, the case manager is alerted and begins to implement a plan of care to reduce the risk points for the patient, Mahn-DiNicola says.

"If each functional department houses their information in a separate system and case management can't access it, they are working blindfolded and have missed an opportunity to impact the clinical course of care," she adds.

This doesn't necessarily mean the risk management department has to be directly involved in the selection of a case management system, but it does mean that you should clarify how you need to share information so the information technology department can make sure it will happen.

Make sure the system you choose will interface with the rest of your hospital's information systems. "One of the problems with a case management system is that some are basically stand-alone and you have to re-input patient demographic and insurance information into them," Spath says.

Once your system is in place, don't fall into the trap of spending a lot of time collecting information you don't need, just in case somebody asks, she advises.

"Quality data have been collected for years by medical records and the quality department, and they have input it into a system. Just because all of a sudden, case managers are data collectors, that doesn't mean they have to have their own system. They should have access to optional data fields in another system," Spath says.

Rely on your clerical staff to key information into the computer, she adds. "I have been in hospitals with rooms off the nursing unit where RN case managers with great clinical skills spend a lot of their time sitting at the computer doing something that someone who is not so skilled or well paid can do." ■

Access program reduces inappropriate admissions

Nurses are located in all admissions areas

A program that places nurse case managers in all admissions areas of the hospital has helped Our Lady of the Lake Regional Medical Center in Baton Rouge, LA, cut down on inappropriate admissions and transfers and improve patient flow.

The clinical access program was established 2½ years ago to tackle problems with medical necessity, patients being admitted without orders, patients who didn't meet admissions criteria, and coding issues, **Lesley Tilley**, RN, BSN, CCM, administrator of medical services and director of medical management at the medical center told attendees at the 10th Annual Hospital Case Management Conference in Atlanta on March 14.

Now, case managers, called clinical access nurses, handle all direct admissions, all emergency department (ED) admissions, all elective surgery cases, and transfers from other facilities.

"We added a step to the admissions process. All orders are reviewed by nurses, and no one gets a bed unless the clinical access nurses approve," Tilley said.

During an average month, the nurses review approximately 2,000 orders, with about 8% of the status indicators incorrect or absent. However, the orders are reviewed prior to registration so that any issues with appropriate status can be addressed, she pointed out.

The clinical access program reports a savings to the hospital of approximately $1.3 million in charges per month, based on the number of

Medicare and Medicaid charts without proper status, which are corrected prior to registration, Tilley said.

The clinical access nurses work at all access points in the hospital: the main admissions department, the admissions department in the ED, and pre-surgery testing and same-day surgery. They are in constant contact with the bed control staff.

"We didn't want the program to be fragmented, so we located the staff at all access points," she explained.

Although they perform case management functions, the hospital chose to call the staff "clinical access nurses" because, at the time, "case manager" had a negative connotation to the physician staff.

"At the time, the case managers had the reputation with the medical staff for being 'chart Nazis.' The doctors looked to us only when they had problem patients and they wanted us to help with discharge," Tilley added.

There are three full-time equivalent (FTE) positions for clinical access nurses and one FTE position for a licensed practical nurse who reviews surgical orders. The clinical access program staffs nurses seven days a week, two shifts per day from 7 a.m. to 11 p.m.

They certify the admission criteria of every patient before they get a bed, making sure that there is a diagnosis and that enough information is in the chart to ensure the patient meets Interqual criteria for admission. They make sure patients are admitted under the proper status.

House managers are in charge of admissions after 11 p.m. and coordinate all bed assignments, including transfers and trauma patients.

Here's how the system works: Bed control receives a bed request. The clinical access nurse reviews the admission orders and discusses patient status and medical necessity issues with the physician if necessary. The nurse discusses any questionable admissions with the physician advisor. After the clinical access nurse approves the admission and the level of care, the bed coordinator assigns a bed.

"The clinical access nurses aren't concerned about what bed a patient is assigned to. They are involved in making sure that the patient is admitted to the best level of care," Tilley said.

The clinical access nurses talk to almost every admitting physician before the patient is assigned a bed and make sure the bed status is appropriate. If there is a question about medical necessity, they turn to the physician advisor, who reviews the chart and intervenes if necessary.

The new process has ensured that patients are placed appropriately and decreased the number of patients who are transferred to the intensive care unit (ICU) because they are in the wrong level of care, she says.

If patients are frequently admitted for chronic problems, the nurses can get them admitted directly to a skilled nursing facility or a long-term acute care facility, rather than tying up hospital beds.

Our Lady of the Lake Regional Medical Center has 800 licensed beds, 30,000 admissions, 70,000 ED visits, and 18,000 surgeries a year with an average daily census of 457. As the largest tertiary care hospital in Louisiana, the hospital serves patients from a widespread rural area.

Before the program was established, patients were being admitted to the floor from the ED without orders, and it sometimes took as long as four hours before the orders were faxed to the floor. An audit of one-day stays by the hospital's peer review organization showed the hospital wasn't compliant.

Physicians were admitting patients inappropriately, such as admitting them to telemetry beds when an ICU bed wasn't available, resulting in transfers of patients to the ICU.

Referring hospitals were sending patients to Our Lady of the Lake because they had been in their facility a long time and were running out of benefits but had nowhere to go.

"That really affected our patient flow because we had inappropriate patients in the beds and we weren't able to discharge them," she added.

Tilley had been director of medical management for just six months when the hospital decided to tackle patient access. "My boss was 100% behind it, but it was still overwhelming. The fact that our doctors didn't like working with case managers at the time made it more of a challenge," she said.

Before beginning the project, Tilley and her team looked at patient data to determine when and where the services were most needed. They used data from an outside audit and did their own audit, determining which physicians were admitting patients, where they were being admitted from, and which days of the week and times of day had the heaviest admissions. They looked into how housekeeping issues affect admissions, checking for any times of day that there were backlogs in bed availability.

They studied the bed coordination and bed assignment process and assessed the educational

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CRITICAL PATH NETWORK™

Holistic wound care yields better healing rates

One nurse provides hands-on care, plus CM

The wound care center at Presbyterian Hospital of Plano (TX) takes a holistic approach to patient care by assigning each patient to one nurse who provides hands-on care and case management.

"We found that providing all aspects of patient care and case management was a really good change for us. The nurses have expressed more satisfaction, and we believe we provide better patient care by taking a holistic approach," says **Kathy Zeller**, RN, BS, director of the wound care center, who adds that wound care case managers typically aren't found in the outpatient setting.

The case management piece is unusual in the outpatient setting. The outpatient wound care case management program has paid off in outcomes that have improved steadily, Zeller adds. In 2003, the hospital's healing rate was 96%. This year, it exceeded 97% in the first quarter and was 100% in the second quarter. "It has to do with having a good team that works together well," she says.

The staff at Presbyterian Hospital's wound care center all are registered nurses, with the exception of office staff and a nursing assistant. Nursing staff all are cross-trained to handle both wound care and case management. "Everyone knows the whole case management philosophy. They can pitch in and take care of patients' needs, document on the chart, and handle all of the patient coordination," she says.

The RNs provide the wound care and work as case managers for their patients, coordinating home health services, durable medical equipment supplies, transportation issues, and making sure the patients get their prescriptions filled. "They get into the entire realm of case management, including documentation and medical necessity questions as they arise," Zeller explains.

Zeller joined the center in 1998. In 2001, she decided to involve all the nurses in the wound care center in case management activities. "I felt it would work better if everyone was trained the same way to provide the full level of care," she says.

Each nurse case manager handles all the patients of the physicians to whom he or she is assigned. The case manager accompanies the physicians when they see the patient and work with the primary care physician on any subsequent issues.

The nurse case managers make sure that everything the physician orders is carried out, that the patients get scheduled for the tests in a timely manner, and that the physician and patient are notified of test results.

The wound center runs 10 half-day clinics at Presbyterian Hospital of Plano, one all-day clinic in Allen, and one half-day clinic in Flower Mound each week. The clinics are staffed by physicians in individual practices, among them a vascular surgeon, plastic surgeon, and a podiatrist.

The case managers typically cover patients in one to three clinics. The rest of the time, they work as intake nurses or a wrap-up nurses in other clinics, providing the patient education and making sure the patients understand what they need to do at home.

When patients are referred to the wound care center, intake staff handle the precertification or authorization process and send the patient a four-page detailed assessment form. The nurse case manager accompanies the physician on the preliminary examination. "The physician and case manager are a team. They go from patient to patient

during the clinic. The nurse case manager is the primary contact for the patient," Zeller says.

The nurse case managers give their patients business cards and encourage them to call them with any questions about their care at home. The case manager also is available to the home health nurse or other providers that may be caring for the patient. The patients come every week for the first four weeks and call the nurses if they have any questions. The nurses follow up on biopsy findings and other medical reports. If a patient has to be admitted to the hospital, the nurse case manager organizes the admission.

The average healing time for most patients is 10-12 weeks. Some heal in a few weeks, and others visit the clinic over a longer period of time. Some patients with chronic problems are in conservative care and come in every four to six weeks to make sure their wounds aren't getting worse. The wound center has a vascular laboratory to evaluate patients with circulation problems.

"We offer one-stop care. Quite a few of our patients are elderly, and we make sure they don't have to go all over the hospital," Zeller adds.

The hospital contracts with Curative, a Hauppauge, NY-based company that provides wound care management for more than 100 centers and maintains a database of more than 450,000 patients.

The company provides the hospital's wound center with a clinical pathway for the care of patients with chronic, nonhealing wounds; documentation support and other forms; policies and procedures; educational materials; and marketing materials that offer CME programs for physicians and CE courses for nurses. ■

Is your falls prevention program getting results?

JCAHO will look for evidence of reduced risks

To comply with the Joint Commission on Accreditation of Healthcare Organizations' new National Patient Safety Goal to reduce the risk of patient harm resulting from falls, your organization must assess and periodically reassess each patient's risk of falling — including the potential risk associated with the patient's medication regimen — and take action to address any identified risks.

However, even if your organization has a falls prevention program in place, it doesn't mean you're getting significant results. At St. Marys Hospital Medical Center in Madison, WI, a program had been in place for years to prevent falls, but the organization wasn't seeing a reduction in the fall rate.

"Our population was getting older, sicker, and more acute," says **Christine Baker**, RN, PhD, APRN, BC, CEN, clinical nurse specialist and director of clinical outcomes management and decision support. "So it was difficult to know if we were actually making gains, when our population was more prone to falls."

The organization's nursing research council began by researching existing fall prevention programs and grading scales. "We decided to borrow from the best of them and then incorporate our own twist," she explains.

All of the existing grading scales ask questions such as whether patients are on a certain medication or if they have fallen in the past year, Baker notes.

"That really takes away that aspect of nursing judgment. You could have healthy people on Lasix who aren't at increased risk of falling; or a patient may have fallen twice on the ice, but that doesn't mean that they are at risk for falling in the hospital," she says.

An algorithm was developed that identified all patients as being at universal risk of falling because of factors such as being sick, sleep-deprived, and in an unfamiliar environment.

"We borrowed that element from universal precautions — something that exists for all patients just because they are in the hospital," Baker says.

A second category of patient is put at higher risk for falls because of specific risk factors such as disorientation. "The last question on the algorithm asks the nurse to put all of that together and make a nursing assessment, as to whether this patient is at high risk for falls," she adds.

Even after the algorithm was implemented, the fall rate didn't drop significantly, so the organization trialed two interventions. The first was a protocol that reduced the use of sleeping pills, particularly those that had long half-lives and would make patients drowsy the following day. Instead, patients were offered comfort measures such as a backrub, warm milk, or herbal teas.

"Although physicians did adopt the protocols and use of sleeping pills dropped markedly, we still didn't see significant reductions," Baker says.

"Where we saw our payoff was in our 'Safe Room' setup — we cut our fall rate by half."

This intervention involved making the patient's room safer, by placing intravenous poles on the same side where the patient would exit the bed and removing physical barriers so patients were less likely to trip on the way to the bathroom.

As a result, the number of patient injuries related to falls fell sharply. "By having the beds in a low position, the patient didn't have far to fall," she says. "We'd like to prevent the fall, but if it happens, to have no injury result is the best outcome."

Posters placed in every room reminded family and visitors to call a staff member to assist the patient with getting to the bathroom, as opposed to trying to help the patient themselves. "So we involved another pair of hands and eyes in watching the patients," Baker explains.

"We also teach patients who are cognitively intact about how to prevent falls, such as using their call light and not trying to exit when there's a side rail up," she notes

As a result, the severity of injuries has dropped significantly, Baker says. "It's been a long time since we had more than a minor bump or bruise from a fall. The nurses are pleased as well.

"It was frustrating to put a patient on fall precautions when they knew the patient wasn't really at risk. Also, this gives them license to use the protocol when the nurse has a gut feeling that a patient is at risk, even if they don't screen in," she continues.

The organization uses comparative data from the Maryland Hospital Association database and the National Database of Nursing Quality Indicators to set fall-rate goals for the year, which are incorporated into the annual nursing QI plan.

"Each unit reports fall rates at a monthly QI council. If they exceed the fall-rate goals, the unit has to have a plan in place to bring the fall rates down," Baker notes.

Facilitywide, patient-specific interventions

The organization's fall prevention program recently was revised by its falls workgroup to reflect the most current research. "What we needed to do was clarify things that should trigger a reassessment, such as the patient coming back from surgery and a new medication added," she explains. "Typically, patients are reassessed after a shift, but something could happen mid-shift to increase a patient's risk of falling. Every time you have patient contact, the caregiver should be thinking: Has anything been done to put this patient at risk for falling?"

At the VA Medical Center in Lexington, KY, patient falls have been incorporated in the incident reporting system for many years, says **Linda Cranfill**, quality manager. "But with the evolution in patient safety approaches in recent years, we have taken fall analysis, assessment, and prevention to new levels," she says.

One effective strategy involved the use of hip protectors, which provide padding so fractures can be prevented if a fall does occur, Cranfill says. The implementation of hip protectors resulted in a projected cost savings of $16,065 to $44,415.

Another major change was the implementation of a falls collaborative group. "Nationally, the VA requires its facilities to do aggregate root-cause analyses on patient falls," Cranfill notes. "Our falls collaborative group does those, and much more, here. They are the core group for aggregating and analyzing data as well as for developing and implementing improvement strategies."

A combination of facilitywide and patient-specific interventions has resulted in dramatic improvement in both fall and major injury rates, says **Mary Ann Ford**, RN, MSN, CRRN-A, the VA's director of utilization management. "The acute medical-surgical units have had a 20% reduction in the fall rate and no major injuries for 2½ years," she reports.

Some of the interventions include:

- education of interdisciplinary staff on fall risk assessment and fall prevention interventions;
- integration of the fall risk assessment into the electronic initial nursing assessment and reassessment;
- implementation of tools for more in-depth patient assessment to identify factors that could be modified to decrease fall risk, such as gait and balance assessment in nursing home care units, revised drug regimen review, delirium management guidelines, and orthostatic blood pressure guidelines;
- use of hip protectors, low beds, signs posted in patient rooms as reminders to call for assistance, bed alarms, exercise programs, and toileting programs;
- initiation of the use of flip charts or fall communication boards on the units to improve communication among staff;
- ongoing feedback to staff about results of their efforts.

"We measure the success of our fall prevention program with the outcome measures of fall rate

and major injury rate, using national and internal benchmarks," says Ford. "A rate is used in order to take into consideration fluctuation in patient census."

The fall rate is the number of falls per 1,000 days of care, and the major injury rate is the number of major injuries per 100 falls. Additionally, to aid the review team and target interventions, fall data aggregation also includes tracking circumstances surrounding the falls, such as history of falls, where and what time falls occurred, and patient cognitive and functional abilities, Ford says.

Data are collected via incident reporting and analyzed quarterly by an interdisciplinary team that includes the patient safety officer. Analysis of fall and major injury rates is done through the use of run charts, noting when interventions were implemented, and circumstances of falls are analyzed with bar graphs and run charts.

Staff education efforts have focused on assessment of patients for risk of falls, and identification and implementation of strategies to reduce risk of falling or risk of serious injury should a fall occur, Ford says. "The education focuses on basic fall prevention interventions and individualized patient care," she says. "I recommend that a valid, reliable tool be used to provide a basic assessment and periodic reassessment of risk of falling to guide staff toward taking actions to reduce the risk of falling."

Top health care industry executives say greater use of information technology, practice guidelines, patient safety measures, and disease management programs would improve quality care and contain costs, according to a new survey by Harris Interactive.

The survey found that 40% of respondents believe that employing a combination of IT, practice guidelines, and patient safety measures is an effective and desirable way to contain health care costs. Furthermore, 27% listed disease management programs as the second most effective way to manage costs. In the survey, 38% said slow adoption of IT poses the most serious threat to the health care industry, closely followed by rising medical costs (37%) and the increasing number of uninsured/or underinsured (34%).

More than two-thirds of respondents who work for hospitals, physician practices, or health insurers say their organization has increased or accelerated their investments in clinical IT and electronic medical records, and an additional 15% plan to make new investments soon. ■

CE *questions*

17. The GAO estimates how many pages of medical records are generated each year?
    A. 500 million
    B. 10 billion
    C. 20 billion
    D. 1 trillion

18. According to Vicky Mahn-DiNicola, the most successful implementations of technology are a collaboration between the CM department and which other hospital department?
    A. nursing
    B. administration
    C. information technology
    D. admissions

19. Medicare will pay for patients with end-of-life conditions to be in hospice care for how long?
    A. 6 months
    B. 3 months
    C. 1 year
    D. 6 weeks

20. At Our Lady of the Lake Regional Medical Center, clinical access coordinators work at all access points in the hospital: the main admissions department, the admissions department in the emergency department, and pre-surgery testing and same-day surgery.
    A true
    B. false

Answer key: 17. B; 18. C; 19. A; 20. A

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 70)

needs of the medical staff and employees.

Goals for the program included:

- enhancing the quality of care delivery;
- creating a patient- and physician-friendly environment for access;
- controlling resource utilization;
- establishing admissions criteria;
- verifying proper status indicators;
- meeting corporate compliance requirements.

Tilley and her staff developed the program with the help of their physician advisor, who brought the plan to the medical executive committee. "He told doctors why it was important to get their support for this new program. One goal of the program is to enhance the quality of care delivery by ensuring that patients are admitted with orders and eliminating waits for care. This was a strong selling point with the hospital's physicians," she added.

The program is staffed with experienced nurses with knowledge of Interqual criteria, familiarity with community resources — such as home health and durable medical equipment providers — who understand Centers for Medicare & Medicaid guidelines and other regulations and are knowledgeable about managed care contract structure.

The nurses began immediately to establish a positive relationship with the physicians.

"We wanted these nurses to be the frontline ambassadors for patients and physicians, someone the patients can talk to while they are waiting for admission and someone the physicians can use as a resource," Tilley explained.

The team received approval from the hospital's compliance office and senior manager and began to educate all employees who are involved in any way in the admissions process. That included nurses, the ED staff, the admissions staff, the case management team, the medical staff, and the house managers. "The education process took longer than coming up with the idea and designing the program. We changed the way things work, which is sort of like turning a ship around," she said.

The department tracks the number of charts reviewed daily, number of inappropriate status indicators by physician, number of inappropriate admissions, and number of inappropriate transfers. The physician advisor discusses inappropriate admissions and status indicators with individual physicians. Tilley compiles the percentage of total admissions reviewed, charges or costs associated with charts without appropriate status, and reports monthly to the CEO, the CFO, and the COO.

"We can look at Medicaid and Medicare payments and show how making sure a patient is appropriately admitted saves revenue," she pointed out. ■

CMs coordinate care for patient at end of life

Hospice team supports families, each other

A team approach to hospice care helps members of the interdisciplinary team provide support for patients and each other at HealthEast Hospice Care, based at St. Joseph's Hospital in St. Paul, MN. The hospital is part of the HealthEast Care System, also in St. Paul.

Nurse case managers lead the program's interdisciplinary hospice teams, which include social workers, who provide family support and counseling, bereavement counselors who work with the family for up to a year following the death, chaplains who coordinate spiritual care, a medical director who works exclusively with the hospice program, and the patient's own primary care physician.

The team also includes the volunteer coordinator who recruits, orients, and trains volunteers from the community. The role of the volunteer is to provide administrative support and supportive care for the patient.

Home health aides, working closely with the RN case manager, provide personal care for the patient. "Everyone on the team works together to support each other," says **Beth Spottiswoode**, RN, BSN, director of hospice care for HealthEast Hospital System.

Team conferences are a cornerstone of the program that helps facilitate patient care and gives team members a chance to discuss any issues or concerns. The interdisciplinary team meets twice a week with the medical director and reviews each case, compiling a report for the primary care physician.

During the conferences, each member gives updates on his or her patients and asks for suggestions or support from the other team members. For instance, if one person has just had an upsetting experience with a stressed-out family, he or she brings it up with the team and they discuss it.

"It takes a special person to work with patients in a hospice situation. The team works closely

together, and they support each other when a team member has had a difficult time," Spottiswoode says.

The hospital-based hospice program offers a combination of hospital and home-based hospice care. Patients may be admitted to designated hospice beds in the hospital or assigned to The Pillars Hospice Home, an eight-bed residential facility in the community, but the majority of care takes place in the patient's or a family member's home, assisted-living centers, and nursing homes.

"The whole goal around hospice is to support and manage a good dying process for individuals with terminal illnesses and to have healthy family survivors following the death," Spottiswoode notes.

Case managers and social workers are paired and care for the same patients in the same geographic area.

The nurse case managers who travel to the patients' homes have a caseload of eight to 12 people. Those who see patients in long-term care facilities where they may have several patients in one location, can handle as many as 15 or 16 patients at a time.

The nurse case managers and social workers work as a team, sometimes making joint visits and staying in constant contact by cell phone and beeper.

When the case is first referred for hospice care, the nurse and social worker visit together.

"We don't meet with anyone alone. We make sure the patient has a supportive person with them when we give them information about the program," Spottiswoode adds.

How the program works

Here's how the program works: First, the program's admissions nurse and social worker visit the patient to admit him or her into the program.

For a patient to be admitted to hospice care, the physician has to medically certify that the patient's disease is at an end stage. The patient or his or her authorized representative has to sign a consent form indicating that the patient is willing to participate in a hospice program.

HealthEast Hospice Care also requires written consent from the primary caregiver, accepting responsibility to be the spokesperson for the patient. Once someone signs onto the program, the program registers them with the medical examiner's office in their county as an expected death, to occur at home, saving the family the trauma of having to have the police come out when the patient dies.

When a patient is admitted to hospice care, the RN case manager visits the family and makes a physical assessment of the patient, his or her condition and needs, and begins to develop and coordinate the plan of care.

Working with the medical director and the patient's primary care physician, the case manager comes up with a detailed plan of care that will help family members manage advanced illness symptoms at home. The plan of care includes the frequency of visits by members of the interdisciplinary team, based on the patient's needs, and the ability of family members to care for him or her.

The case manager assesses the patient's need for equipment, orders it, and makes sure it is delivered. The program's standard equipment includes an electric hospital bed, wheelchair, walker, commode, and oxygen concentrator.

"We do whatever we have to do to manage the symptoms. Not everybody has the same needs," Spottiswoode says.

When the plan of care has been developed, the case manager and social worker visit the family and discuss the plan with them.

Two weeks to a month later, the team sets up a family care conference, led by the social worker, where the family can ask questions, discuss their concerns, mention any needs that aren't being met, and receive support.

The case manager visits the patients regularly, usually two to three times a week, assessing the condition and providing hands-on care to help manage any problems that occur, such as constipation, a frequent side effect of pain medication. The program has routine standing orders for medications to manage symptoms if the need arises, eliminating the need to call the physician for approval when something comes up.

"We try to manage the symptoms with a low-tech approach. As you increase technology in the home, you increase the need for professional visits. We try to be respectful of the family and not make unnecessary visits," Spottiswoode notes.

For instance, the case manager works with the pharmacist to get concentrated medications or patches that will provide pain medicine topically, to avoid the use of IV drugs.

"We work to keep the family system intact so that they are able to care for their loved one with our support, rather than going in and assuming all the care needs because we think the family can't manage it," she says.

If the family is unwilling or unable to provide personal care for the patient, such as bathing and changing the bed linens, the case manager schedules home health aides to visit several times a week.

The home health aides stay in close touch with the case managers, alerting them if the patient's condition has changed. The case manager then visits the home again and assesses the patient to determine if he or she needs a change in treatment or to be moved to a different level of care.

The case manager works with the hospice program's medical director and primary care physician when the patient's symptoms become difficult to manage or there is a change in condition.

They collaborate on changes in the plan of care, including moving the patient to another location. "It is obligatory that the majority of deaths do occur at home. That's the whole intent of the hospice movement," Spottiswoode says.

Under the Medicare requirements, HealthEast Hospice Care provides four levels of care: routine home care, including home visits by the multidisciplinary team, medications and special equipment; general inpatient level for care when the patient's care can't be managed at home; respite care of up to five-day stays to give the primary caregiver a break; and continuous care, providing round-the-clock nursing care, usually for a duration of 10 days or less.

The case manager is responsible for changing the levels of care when it's appropriate and working with the rest of the team to coordinate care and communicate the needs of the visit.

All members of the interdisciplinary team are in the office at least once a day. The case managers either come in each morning and go home directly after they finish seeing their patients, or they start from home and come to the hospital to take care of documentation and other paperwork at the end of the day.

They stay in touch by cell phones and beepers. The hospital is in the process of computerizing the program, providing laptops for case managers, social workers, and other team members who provide direct patient care.

Although Medicare will pay for hospice care for up to six months, many referrals come later, says Spottiswoode. The program's average length of stay is 50 days, up from seven days or less when she started working in hospice care in 1991.

"Hospice has stood the test of time. It's now recognized by Medicare and health plans as a cost-effective care plan," she adds. ■

How to explain to clients what case managers do

CMSA-led coalition establishes CM definition

After an exhaustive process that involved collecting more than 150 ways to define case management and testing them in the field, the Case Management Leadership Coalition has come up with a way that case managers can tell consumers what they do.

"Case managers work with people to get the health care and other community services they need, when they need them, and for the best value," is the consumer-friendly definition selected after a year of work.

Because so many people call themselves "case managers" no matter what they do, the Case Management Leadership Coalition, a group of case management leaders who work in various settings, decided to come up with a definition that patients and clients could easily understand.

"There is still a lot of confusion among consumers and in the health care industry because of the many ways that case management is defined. Even though the CMSA Standards of Practice clearly define case management, it doesn't stop people from using the term to mean other things," says **Jeanne Boling**, MSN, CRRN, CDMS, CCM, executive director of the Little Rock, AR-based Case Management Society of American (CMSA).

The group set out to identify the skill sets and knowledge that case managers have so case managers will be identified by what they actually do, rather than just a job title that can encompass a lot of different things, she adds.

The leadership coalition asked patients and clients to complete the statement: "I know my case manager has done a good job because. . . ." Responses included: They help me understand; they educate; they provide options; they coordinate; they listen; they help; they support; they negotiate.

After developing the definition, the coalition tested it with people in different populations — Medicaid and Medicare recipients and the commercially insured — and found it to be user-friendly. Case managers can use the consumer definition of case management in many ways, Boling says.

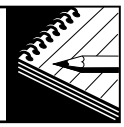
For instance, they can use it to explain their job when they meet a new patient or client. They can

use it in advertising and marketing materials and incorporate it into letters introducing themselves to clients.

The Case Management Leadership Coalition started as a one-time event in 2002 and has evolved into an ongoing group that meets every six months to discuss issues and trends affecting case management and ways that case managers in all settings can collaborate to improve patient care, Boling says.

The coalition is led by the CMSA and the Academy for Certified Case Managers. ■

GUEST COLUMN



What is results-driven case management?

Three questions can help pinpoint CM's value

By **Patrice Spath**, RHIT
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Everyone wants a good outcome from case management services, but not everyone knows what the result should be or how to measure it.

Three fundamental questions can be used to pinpoint the value of case management. The first question is "What results should we get?" This question is about figuring out what you want to achieve with case management services.

The second question is "How well are we doing?" This question is about actually doing the work and measuring or monitoring to see how you are doing.

The third question is "What must we do to ensure that we get results?" This question is about managing the activities of the department to stay on track toward desired goals and about taking corrective action when there is a gap between planned and actual results.

- **What results should we get?**

This question guides the activities of the case management department. It can be a very difficult question, because it must take into account many unknowns about the environment: What could the case management department do that would benefit the organization, patients and their families, physicians, and other caregivers? If "What results should the organization get?" has been adequately answered at the senior leadership level, it is easier to answer at the operational level of case management.

Given the leadership direction, set in terms of the organization's strategic goals, policies, and budgetary constraints, the case management department director can specify "What results should we get?" within the department's sphere of influence.

This is done by determining what the department should accomplish to achieve the organization's strategic objectives. Similarly, individual case managers can figure out a good answer to the question "What results should I get?" if each has clear answers at the department level as a beginning point.

Absent such clarity, people at every level are left to guess about what should be happening and, perhaps, pursue individual agendas.

- **How well are we doing?**

This question is about the current state of case management services — the timeliness, quality, and cost of operations. At the level of the individual case manager, it is about completion of responsibilities and tasks. The question is answered in terms of actual work performance. "How well are we doing?" is about execution of the plan intended to achieve desired results.

- **What must we do to ensure we get the results?**

The first two questions are about planning and execution of case management services. The third question is about managing case management activities to achieve goals. It is about directing case management resources and tools toward desired results. It also is about making modifications when case management performance and expectations do not match. Results-driven case management requires pinpointing the performance that will enhance organizational results, translating those performance expectations into case management goals and interventions, and then measuring progress toward desired results.

Here is an example of how results-driven case management can be applied to a hospital's strategic goal of improving care and reducing costs for patients with diabetes: Senior leaders determine that improving care for patients with Type I diabetes is a strategic goal for the organization. Four related objectives are defined and measures of success identified. **(See chart, p. 79.)**

Achieving the hospital's strategic goal and objectives requires the involvement of many different

professional disciplines, including case management. To determine the role of case managers in achieving these strategic objectives, the case management director first considers, "Within our sphere of influence, what should we be able to do to assist in achieving the results desired by the organization?"

For each of the organization's objectives, one or more important case management tasks are identified. When selecting important case management tasks, the director considers the core functions — assessment, planning, facilitation, monitoring — and the overall measures of success chosen by the organization. For example, to assist in reducing utilization of hospital services, the case managers can actively monitor the appropriateness of patients' continued stays in the critical care unit.

Timely intervention by case managers can help facilitate patient transfers to a general unit when critical care is no longer needed. The director conducts a similar questioning process for each strategic objective.

Once the case managers' contributions toward achieving strategic objectives are identified, then the director determines how this contribution will be measured. How well are case managers doing at meeting these performance expectations? Each important case management task is monitored. The performance measures provide a quantitative answer to the question, "How well are we doing?"

For example, if an important case management task is timely intervention when patients with diabetes no longer require critical care services, the performance measure would be: *Percentage of cases in which the attending physician is contacted by a case manager within 24 hours of the patient no longer needing critical care services.*

If early case management intervention is felt to be a critical factor in reducing the length of hospital

Diabetic Care Strategic Objectives and Measures of Success

Strategic Objectives	Organizationwide Measures of Success
Reduce utilization of hospital services.	• Percent of patients with Type I diabetes readmitted within 30 days for diabetes-related condition. • Percent of patients with Type I diabetes seen in the ED within 30 days of hospitalization for diabetes-related condition. • Average number of critical care days for patients admitted for treatment of Type I diabetes and related conditions.
Improve patients' ability to care for themselves at home.	• Percent of patients with Type I diabetes who report compliance with daily blood sugar monitoring at home. • Percent of patients with Type I diabetes who report satisfaction with instructions provided at the time of hospital discharge. • Percent of patients with Type I diabetes who are able to demonstrate understanding of medication requirements at time of discharge.
Improve quality of care provided to patients with Type I diabetes.	• Percent of admissions of patients for treatment of Type I diabetes or related complications for which physicians follow the standard admitting order set. • Percent of admissions of patients for treatment of Type I diabetes or related complications for which physicians follow recommended treatment plan. • Percent of admissions of patients for treatment of Type I diabetes or related complications for which nurses follow recommended plan of care.

stays for patients with diabetes, then the measure of case management performance would be: *Percentage of patients admitted for treatment of Type I diabetes or related conditions that receive an initial case management assessment within 24 hours following admission.*

The last step is to monitor compliance with important case management tasks. This involves collection and analysis of performance measurement data to determine if expectations are being met. This information affords insight into how well case managers are completing the tasks needed to assist the organization in achieving strategic goals and objectives. If important case management tasks are not getting done as expected, further investigation is needed. A trend of noncompliance influences the sense of urgency for analysis and action. The focus is on identifying the variables affecting less than desired performance and what can be done by the case management department to recover from the shortfall.

Performance monitoring is about keeping case management activities on track toward achieving organizational goals, not assigning blame for what is happening. If a case manager is performing incompetently, modifying that individual's performance would be part of corrective actions required. However, assigning blame, by itself, does little to modify overall departmental performance in a positive direction.

The case management department can best communicate to senior leaders that they are getting a return on their investment by linking the organization's strategic goals and objectives to case management activities. By evaluating case management results through the common lens of the goals established by senior leaders, the contribution of case management becomes easier to communicate. Most important, case management performance measurement results will provide timely, relevant, and concise information that can be used by decision makers — at all levels — to assess progress toward achieving important organizational strategies. ■

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. ■