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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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Delegate clerical functions and free up professionals' time

Case management extenders can maximize time of licensed staff

Delegating nonprofessional functions to a clerical staff can help improve your productivity as a case manager and give your licensed clinical staff more time to spend with patients, according to some case management experts.

Case managers are highly trained professionals, but in many cases, based on the requirements of their job, they are providing clerical activities such as faxing insurance reviews and other documents for discharge planning, copying charts for patient transports, logging in data at the end of the day, and spending time on the phone with insurance companies or ancillary departments.

"These are duties that could be more efficiently accomplished by a clerical assistant, allowing the case manager to have more time for face-to-face interactions with patients and physicians, intervening to prevent delays, planning and preparing patients for discharge, holding interdisciplinary conferences for complex discharge planning, and assuring appropriate documentation," points out **Teresa Fugate**, RN, BBA, CPHQ, CCM manager at Pershing, Yoakley & Associates, a Knoxville, TN-based health care consulting firm.

As she visits other hospitals as a consultant, **Toni Cesta**, PhD, RN, FAAN, vice president of patient flow optimization at North Shore-Long Island Jewish Health System in New York City, often encounters case managers who are frustrated that they have to spend their time faxing, copying, and ordering durable medical equipment.

"These are highly paid professionals who are doing functions that keep them away from the patients. It has never made any sense for them to spend their time that way," she says.

Cesta recommends a model in which one clerical person supports five to seven case managers and is cross-trained to do whatever needs to be done.

"It's a matter of getting the right people in the job, setting up the structure properly, and training them," she explains.

At Cesta's hospital, the clerical staff are entry-level people who are a notch below the secretarial staff.

"It's helpful if you can hire people who have worked in utilization review or the social work department, but you may not be able to find them. They will need training if they haven't worked in health care in the past," she says.

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Most of the training for clerical staff can occur on the job if an experienced clerk is available.

Look for people with good organizational skills and good communication skills since they are the ones who will talk to people outside the hospital and represent your department.

"Clerical staff have a lot to do, but what they do is not complicated," Cesta says.

Utilizing LPNs as case management assistants can reduce the cost of staff since they are paid at a lower rate than RNs or social workers, Fugate says. These staff can perform utilization management reviews, call in clinicals to the insurance company, perform simple discharge planning activities, and assist the case manager in other daily activities, she says.

While adding nonclinical staff to the case management department will help maximize the value of the professional staff by freeing them up to do tasks that require the kind of training they have, there are some pitfalls to bringing new staff in new roles into a department, Cesta says.

It's likely to take some time for the clerical staff to demonstrate their competency and develop a trusting relationship with the case management staff, she warns.

"Some case managers don't want to give up control. It takes time for them to let go of things and to develop a level of confidence in the clerical staff," Cesta says.

Conversely, be careful that your case managers don't develop so much confidence and trust in the clerical staff that they turn over work to them that should be left to the clinical staff.

Typically, case management departments are understaffed, and there is the possibility that professional staff are so overwhelmed that they are tempted to offload some of their work to the extenders, Cesta says.

"Once they develop a trusting relationship with their extenders, case managers may be tempted to ask the clerical staff to do jobs that they are supposed to do," she says.

If you do hire extenders in any capacity, make sure they don't overstep their bounds and perform tasks that should be done by licensed professionals, Cesta suggests.

For instance, Medicare's conditions of participation specify which tasks should be done by the professional staff.

If the extenders are involved in anything that requires a professional's sign off, make sure they are closely supervised, Cesta advises.

There are a lot of variations in the kind of jobs

that case management extenders do and what kind of people are hired to fill the slots, Cesta points out.

Whatever kind of staffing you decide on, develop clearly defined roles and clear expectations so that everyone knows what his or her responsibilities are, she advises.

"There should be a job description that clearly supports the role function. Make sure that the professional staff doesn't blur the line," Cesta says.

Many hospitals are turning toward case management extenders to improve efficiency and effectiveness. *Hospital Case Management* talked to case management directors at four hospitals. In the following case studies, we'll discuss what they do. ■

CM, social work duties handled by specialists

Specialists assist with post-acute placement

At St. Vincent's Medical Center in Jacksonville, FL, three different staff positions handle duties that traditionally have been performed by case managers and social workers.

Two staff assistants handle referrals for home health services, durable medical equipment, ambulance, and transportation services. The staff assistants are notified by the clinical staff when referrals need to be made. They make the referral electronically and get the response back either electronically or by telephone. Then they notify the clinical staff of the acceptances or rejections.

The staff assistants handle the paperwork involved with patient transfers to nursing homes, rehabilitation facilities, long-term acute care, and outpatient dialysis units. They assemble the packet of information that goes with the patient. Both staff assistants have held that position for more than four years. They have high school diplomas and have received training within the department.

The staff assistants are assigned by unit so they work with the same care managers and social workers. They communicate with the clinical staff through beepers and text messages.

A placement specialist works with the social workers on post-acute placement. The social workers notify her when a patient needs placements and give her direction as to which nursing home, rehabilitation facility, and outpatient dialysis center the patient or family member has chosen.

The placement specialist goes into the clinical system, pulls out clinical data, demographics, and other pertinent information and sends it electronically to the facilities receiving the referrals.

"She has no patient contact. The social worker notifies her that a specific patient in a certain room needs to be referred to whatever facility the patient and family have decided upon, and she takes it from there," says **Jamie Zachary**, LCSW, director of care management.

The person originally hired for the position had a bachelor's degree in social work but Zachary determined that a degree is not necessary; when the original employee left, she replaced her with someone with a high school diploma.

"The job obviously requires computer skills. If the social worker had to communicate all the referral information, it would defeat the purpose. The placement specialist can go into the clinical system and pull out all the information she needs for the referral without having to look it up in the chart," she says.

Three payer specialists are each assigned a group of care managers to work with in facilitating the flow of clinical information between the hospital and the payers. If a payer calls and requests clinical information, the payer specialist sends the request to the care manager electronically, and it comes up on the task list.

Working with payers

After the care manager conducts the review, the information goes to the payer specialist, who gets the clinical review to the payer, whether electronically, by fax, or by telephone, depending on what the payer has specified.

"There are some payers who don't call in requesting reviews, but we know that this payer wants a review at some interval. The payer specialists identify those and task them to the care manager," Zachary says.

If an insurance company needs clinicals to complete authorization or precertification, the admissions clerk sends the information to the payer specialists and they notify the appropriate care manager.

"The only time the care managers have any contact with payers is when a payer sends a nurse reviewer on site, and then only if there is a question or a problem. The on-site reviewers check in with the payer specialists and go over the list of the insurer's patients in house. When the on-site reviewers notice an issue related to clinical care,

they bring it to the attention of the care manager.

"Care managers don't call the insurance companies for anything. If authorization is needed for home health or DME, the staff assistants handle it. The placement specialist obtains authorization for placement. If the insurer needs more clinical information, they talk to the payer specialists," Zachary says.

The clerical support staff were added to the hospital's case management model when it was revised in 2002. At that time, the department had one staff assistant who copied charts, ran faxed prescriptions to the pharmacy, and assembled clothing or food for patients who needed it.

Prior to the department redesign, care managers did only chart review with no patient contact.

"Now that we have added clerical support, the care managers have the time to see the patient on their unit, complete a needs assessment, and refer for ancillary personnel as indicated," Zachary says.

Social workers handle all placements and the complex home health needs, such as wound vacs and IV antibiotics.

"We try to keep the care managers focused on care coordination, with the end result being that the patient moves to the next level of care in a timely manner," Zachary says. ■

Bachelor's-prepared staff assist case managers

Work closely with health management specialists

Spartanburg (SC) Regional Healthcare System has just started using health management extenders — bachelor's-prepared staff who work side-by-side with the hospital's health management specialists. The hospital also hires people with an associate degree and at least three years' experience in health care.

"We foresee that as the extenders take the burden off the health management specialists, they will be free to truly work on issues that need their level of expertise," says **Angela Roberson**, RN, BSN, CPUM, manager of health management.

Before creating the new role, Roberson and her team used flowcharts to outline the processes handled by the health management specialists and colored the areas they identified that could be carried out by someone else.

"The role requires a great attention to detail and a certain knowledge and understanding of the health care arena," she says.

Even though the extenders are college-prepared and paid accordingly, it's more cost-effective to hire them than licensed individuals, Roberson says.

"We're expecting they will pay attention to the details and make sure all the detail-oriented pieces that have to happen are there and in place," she says.

Before the new positions were designated, the hospital used clerical staff members to fax and copy. Now the extenders are responsible for those tasks. The hospital has a new computer system for referrals to post-acute services that both the health management specialists and the extenders use.

A wealth of knowledge

After the health management specialist has assessed for need and set the initial wheels in motion, the health management extenders take it from there, contacting multiple providers, setting up care or equipment, and making sure that the transfer occurs in a timely manner.

"We feel that when we are asking people to set up post-acute placements and to be held accountable, along with the health management specialists, they need to be college-prepared," she says.

"These people are actually trained in many of the processes we carry out in our department, but they don't come out of school able to sit for the nursing exam or social work certification. They have a wealth of knowledge and no way to use it. The extender role is perfect for someone with that type of degree and a high level of knowledge about health care," she says.

The goal of the new level of employee is to free up the health management specialists to spend more time with difficult utilization management and discharge planning cases.

"It's becoming more and more difficult every day. Unemployment rates are high here and many people have been faced with difficult issues. We are hoping this will free up the health management specialists to spend more time with them," Roberson says.

The hospital started with three extenders, approved by the administration who recognized the benefit of freeing up the licensed staff.

"We feel like the impact will be great and that we probably will have enough work for four or five extenders," Roberson says. ■

Staff move patients through the continuum

Daily dashboard monitored throughout the day

At Good Samaritan Hospital in Baltimore, support staff collaborate with case managers to follow up on tests, consultations, evaluations, and other procedures, making sure anything that could impede a patient's progress is carried out in a timely manner.

On a "daily dashboard" on the electronic case management system, case managers enter "rate-limiting" procedures that have to be performed before the patient can move to the next phase of care. The support person monitors the dashboard throughout the day and contacts the ancillary department whenever a procedure has to be completed before the patient can progress in treatment or discharge.

"In many places, case managers simply identify delays after they happen, retrospectively. We are taking that same reporting process to a concurrent level. Most often these delays surface because of poor orchestration or scheduling," says **Steve Blau**, LCSW-C, director of case management.

Case managers are good at identifying medical management barriers that impede a patient's progress, but they don't have enough time to communicate with all the ancillary departments necessary to get all of the tests and procedures completed to keep patient flow moving, he says.

"If case managers have to make a number of phone calls to get any number of consults started and also have to negotiate a patient's place on an ancillary department's schedule, they don't have time to see their patients. This system allows them to identify a problem and signal through an automated system for the support person to follow up," he says.

The case managers use their clinical judgment as to what priority the procedure should have. For instance, a patient who needs a physical therapy consult and is expected to be in the hospital for a couple additional days will have a lower priority than a patient who is closer to discharge and the same evaluation is necessary to determine an appropriate disposition.

"Whatever operational barriers exist, we are making sure the staff are alerted. We have the clerical staff make the calls because the case managers simply do not have time," Blau says.

Good Samaritan's support person has a high school education, computer skills, and "incredible people skills. She networks with the clerical staff in other departments and makes it work," he says.

When the case manager indicates that a procedure needs to be performed quickly, the clerical person in case management contacts the clerical person in that department and takes an active role in making the appointment and ensuring that the patient is moved up on the schedule.

Without smart systems, people who work in the ancillary departments don't always have a clear understanding of patient priorities and often take patients in the order that the orders for procedures come in.

"Ancillaries are only as effective as the system that is in place to help them be effective. We challenge them to think about their schedule and give them the information they need so they can meet the priorities of the hospital," he says. The goal, ultimately, is to provide timely information to allow ancillaries to self-organize around patient needs and priorities. ■

CM extenders work in off-site center

Referral specialists are assigned to clinical teams

At the University of Wisconsin Hospital and Clinics, the case management support team is in an off-site Resource Center.

The Resource Center is staffed by payer specialists and referral specialists who take care of the nonclinical details often assigned to case managers.

Payer specialists are assigned by payers and review companies and typically make 60 to 70 telephone calls a day, taking care of clinical review requirements. Case managers enter the clinical review information into the case management software, where the payer specialists can access it.

"This has freed up the clinical staff to work within their team, rather than have the case manager or social worker on the telephone on hold for 20 minutes. Now they conduct their clinical review and the payer specialist gets it to the insurance company," says **Barbara Liegel**, RN, MSN, director of coordinated care. Her department includes case management, social work, utilization review, and discharge planning.

Referral specialists are assigned to clinical

teams and take care of the day-to-day details the team delegates.

For instance, they check out patients' insurance to determine what durable medical equipment or home health care the company allows, set up transportation, and check the availability of nursing home beds.

"There is a lot of work that supports discharge planning, but you don't need a licensed professional to handle faxing, copying, and telephoning. It all can be done by a support person," Liegel says.

The department has been able to decrease the number of support positions by moving them offsite and centralizing them, rather than being on site and working with the teams, she adds.

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CMs face challenges of Hurricane Katrina

Hospital cared for thousands of evacuees

For case managers at Our Lady of the Lake Medical Center in Baton Rouge, LA, Hurricane Katrina presented challenges most people can't even imagine.

"As people left New Orleans, Baton Rouge was quickly overwhelmed by the number of patients with special needs. Our Lady of the Lake was the first responder to the special needs shelter here in Baton Rouge where the majority of people needing medical care were triaged," says **Lesley Tilley**, RN, BSN, CCM, divisional director of nursing and administrator of medical services.

The hospital's 20 nurse case managers and 13 social workers put in 12-hour days for an entire week, helping keep the situation calm and providing support and care for the patients wherever needed.

The hospital was quickly inundated with hurricane evacuees who had tremendous psychosocial needs, spotty medical records, and no place to go after discharge. Insurance information for most patients was not available, and the web site that approves Medicare days was down.

The patients who came to the hospital had been through a tremendous trauma and needed a sympathetic ear to hear their story.

"During a normal cycle, the case managers go in and assess the patients, develop a plan of care and a discharge plan. They're great at it, but the needs of these patients were overwhelming," Tilley says.

Assessments typically took case managers and social workers twice as long as they would under normal circumstances, and discharge planning was hampered by the fact that there were few places for the patients to go and the transportation services were overwhelmed.

"We would have 20 patients in the hospital ready for discharge, but the staff couldn't just send them home with no place to live. All of these patients needed a place to stay and a ride home," Tilley recalls.

The hospital used its fleet of vans to transport patients back to the special needs shelters and bought bus tickets and airplane tickets for numerous patients whose families were in other areas.

"We didn't want to put them in a shelter if we could avoid it, so we found the family and helped them get home," she says.

The case management department's community resource book was an invaluable resource following Hurricane Katrina. Staff from all parts of the hospital used the information to find community services for their patients.

"Having up-to-date information that is available to everyone in the hospital is a big plus. The case managers and social workers were so overwhelmed that we had to call on the other departments to help with post-acute transfers," Tilley says.

Except for a few patients who were directly admitted from New Orleans hospitals, the majority of patients with health care needs coming out of New Orleans were triaged at two special needs centers. Baton Rouge hospitals provided the supplies and staff to care for these patients for many days.

Many of the patients who needed hospitalization were directed to Our Lady of the Lake.

"Our hospital is the only one in the area with some special services. We have the largest pediatric unit and pediatric intensive care unit in the city, the only neurosurgical and trauma programs. The doctors tried to triage the patients because they didn't want to overburden our hospital with patients that could be treated elsewhere," she says.

In the first few days following Hurricane Katrina, case managers and social workers at Our Lady of the Lake Medical Center concentrated on crisis management rather than their regular duties,

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CRITICAL PATH NETWORK™

Initiative helps hospital improve quality indicators

CM in HR ensures Core Measures are followed

The percentage of patients with community-acquired pneumonia who received antibiotics within four hours of admission doubled in just three quarters after the staff at Saint Luke's Health System in Kansas City, MO, instituted a process improvement initiative.

For the first quarter of the year, only 40% to 42% of patients admitted from a physician's office were meeting the Centers for Medicare & Medicaid Services (CMS) Core Measure for antibiotic administration. By the fourth quarter, the figure rose to 86%.

The 582-bed tertiary care hospital recently revised and consolidated its 163 clinical pathways, resulting in 75 pathways with corresponding order sets. The pathways are outcomes oriented and are based on Milliman criteria for moving patients through the continuum.

The hospital's case management department operates within a triad model in which case managers and social workers are assigned by unit and work directly with the RNs on the unit as a team.

The case managers all are RNs who conduct the medical review and assist with payer requirements for utilization review. The social workers are in charge of the psychosocial evaluations and the final discharge plan.

"The staff nurses and attending nurse are in constant communication with the case managers and social worker to ensure that the quality measures are being met and to focus on what the patient needs to move along the continuum of care," says **Anita Messer**, RN, MHSM, ACM, director of care integration.

One key in the improvement of antibiotic administration for pneumonia patients is a case manager whose duties include working with the admissions office to make sure the order set and clinical path are initiated when the patient is still in the admitting office of the hospital.

When a physician's office calls the admissions office to announce that a patient with pneumonia is coming in, the case manager is alerted. He or she calls the physician's office, initiates the order set for pneumonia, and takes the order for the antibiotics from the physician.

The case manager accompanies the patient to his or her room, notifies the nurse of how much time has elapsed, reminding the nurse that the patient needs the antibiotics within four hours of admission.

The case manager is part of the transfer team that screens patients who have been transferred from other facilities and is called into admissions to follow patients with pneumonia. The process has been so successful that the hospital plans to expand her role to include other diagnoses, such as congestive heart failure and chronic obstructive pulmonary disease (COPD).

A multidisciplinary team, working under the hospital's Office of Clinical Practice Guidelines, a division of case management, began by examining the pathways and order sets for community-acquired pneumonia and looking for ways to ensure that the criteria are met.

"It was a huge collaborative effort. The case managers had been working with the pathways and order sets and were given the lead in the project. We included the nurses from the floor where the majority of pneumonia patients were admitted, hospitalists, laboratory representatives,

and the pharmacy. We looked at how the process of ordering labs or antibiotics worked or didn't work," says **Melissa K. Thomas**, RN, MSN, CPHQ, clinical project manager at the 582-bed tertiary care hospital.

The team began by identifying the units that have a high number of admissions with pneumonia and working with them to assure that the antibiotics are administered in a timely manner. The pharmacy has worked with the nursing staff on those units so that the most common drugs prescribed for pneumonia are stocked in the automated pharmacy distribution system so the nurses don't have to order them from the pharmacy and wait for delivery.

"When you have just 120 minutes, you've got to have a turnkey operation to ensure that everything happens in a timely manner," Thomas says.

The team worked together to identify barriers and determine how the barriers could be improved. They monitored the processes that had been put into place to make sure they worked.

For instance, a stat sleeve was utilized to expedite obtaining the antibiotic from the pharmacy. The stat sleeve is a plastic sleeve in which the pneumonia order set is sent to the pharmacy. They checked to make sure the stat sleeve cued the pharmacist to unlock the antibiotic.

They also checked to make sure the case manager in admissions assured that the order set was implemented.

While the process improvement project was under way, a member of the PI team, usually **Brent Beasley**, MD, the physician leader, went to the floor as an observer and followed the process when the case manager was notified of a pneumonia admission.

"We followed the patient through the process and determined what the team did when the patient got to the floor, when the orders were faxed to the pharmacy, and if all the triggers we had in place were followed," Thomas says.

The process improvement team leaders acted strictly as observers and didn't step in when something needed improvement.

"The whole goal was to verify what processes were in place and see where any breakdowns were in the process," she says.

When Beasley saw opportunities where his colleagues could improve what was being done, he made a note of it and talked with them later.

"He asked them how we could work around the barriers and brought back a lot of information on the process flow," she says.

The case management and nursing staff work together on all the units to achieve outcomes for the patients.

"The staff nurses are key in making sure the patients are on the pathway and in making sure that their day-to-day needs are met. They coordinate with the case managers to medically manage that patient and make sure everything is in place," Messer says.

The social workers work with the patients and families to make the final placement after discharge, helping the family do whatever is needed to achieve the best outcome.

Saint Luke's has had clinical pathways since 1990. Three years ago, the Office of Clinical Practice Guidelines was started through the case management department and charged with reviewing the pathways to ensure that they were evidence-based, up-to-date, and that the clinical pathways and orders sets matched.

The pathway team includes the physician champion, a staff nurse champion, pharmacy, nutrition, laboratory representatives, and case managers. "These are frontline people who know the disease process and how to treat the patient effectively and move the patient along safely," Messer says.

All of the CMS Core Measure are included in the pathways.

The team revised the pathways to include the Milliman criteria and reformatted them to make them outcomes-oriented.

Instead of Day 1, Day 2, the pathways are divided into phases — Admissions Phase, Acute Phase, Stability Phase, and Discharge Phase, all following Milliman criteria. Instead of listing tests, procedures, consultations, and nursing tasks, the revised pathways are replaced by the body system — using neurology, cardiology, GI, and muscular skeletal divisions when each is appropriate.

"It's more physiology based and in sync with how the nurses and physicians interact with patients," Messer says.

Each phase of care contains Milliman criteria and outcomes. For instance, the admission phase of care on the community-acquired pneumonia pathway includes blood cultures and administering anti-biotics within four hours of admission, along with the Milliman clinical stability indicators and qualifying criteria the patient must meet to move to the acute phase.

"We don't have patients falling off the pathways any more. If they're not responding or meeting outcomes, the nurses, case managers,

and physicians can look to see if this patient is doing something different," Thomas says.

Since few patients come in with one disease process, the revised pathways allow staff to move patients from one pathway to another.

For instance, a patient with COPD was admitted with community acquired pneumonia and, before the Stability Stage was accomplished, the pneumonia had resolved. His fever was gone and his white blood count was normal, but the pneumonia had exacerbated his COPD.

"Rather than taking him off the clinical pathway altogether because he no longer met criteria and he had met the outcomes, the nurse switched him to the COPD pathway, and the care of this patient continued until he could be safely discharged," she says.

The office conducts random chart audits to see if the pathways for the most frequent diagnoses are being followed.

"We know that if we get good outcomes for the patient population on the pathway, this will convince the staff to follow the pathway," Thomas says.

The treatment team collaborates and shares accountability for ensuring that the patients are on the pathways. If the case manager sees that a patient has been admitted and the pathway hasn't been started, he or she talks with the nursing staff and gets the pathway initiated.

If the nursing staff has a patient on the pathway who isn't moving along, he or she contacts the case manager and asks for help moving the patient through.

"What has made a big difference in compliance has been our physician leaders who collaborate with their colleagues and encourage them to use the order sets with the matching clinical path. In the last several years, we've made great inroads in the right direction for patient care because of the physician leadership," Thomas says.

St. Luke's commitment to quality and continuous improvement quality earned the prestigious Malcolm Baldridge National Quality Award in 2003. The hospital has adopted the Baldridge Criteria for Performance Excellence as its business model.

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Nurse line checks up on patients after discharge

Referrals made for patients who need follow-up

When a case manager or social worker at Saint Luke's Medical Center is concerned about a patient who is being discharged, he or she asks the RNs staffing the hospital's Nurseline to make a follow up call after the patient gets home.

Since the program began in May 2004, more than 100 patients have been referred to the Nurseline for follow-up and only eight of these have been readmitted — none for anything connected with the original admission, says says **Anita Messer**, RN, MHSM, ACM, director of care integration for the Kansas City, MO, hospital.

The Nurseline originally was established so patients could call in with questions after they left the hospital. The program has been revised to include outbound calls for patients who are flagged by case managers or social workers for post-discharge telephone calls. The initiative is budget-neutral since the hospital already had the Nurseline in place.

"These are patients we're concerned about after they leave the hospital. They aren't sick enough for home health care, but the social worker or case manager has identified some issue about their safety. They may not understand their discharge instructions and may need more help with this after they get home," says **Melissa K. Thomas**, RN, MSN, CPHQ, clinical project manager.

The hospital has follow up for patients with some chronic diseases, such as congestive heart failure, but there are others who need assistance but don't qualify for post-discharge services.

"One of the main goals of the program is to catch patients who in the past may have fallen through the cracks. These are other patients who are not sick enough to qualify for home health or other services but are at risk for having to be readmitted if they don't make a doctor's appointment or get their prescription filled," Thomas says.

The order in which the discharged patients are called is based on an acuity system.

If a nurse or case manager identifies a patient as high acuity, the process is followed to flag Nurseline, and the patient is called the day after discharge.

If patients are low acuity, the Nurseline nurse calls them a few days later to make sure they are taking their medication, that they've scheduled a follow-up appointment with their physician, and

are experiencing no signs or symptoms that might indicate complications.

When a case manager or social worker identifies a patient who meets criteria, they put it in the chart. The information assistant (or unit secretary) flags the patient on the electronic medical record and faxes the discharge summary to the Nurseline. The fax includes information about the acuity level of the patient's follow up needs, what follow-up should be done, what medications were prescribed, and what the discharge instructions are.

"This initiative allows us to follow our patients after discharge and gives the nurses, the case managers, and social workers peace of mind. We've been able to prevent complex medical problems from occurring and to ensure that the patients are doing everything they need to do to recover quickly," Messer says.

For instance, when the Nurseline nurse called a man who was recovering from cardiac surgery, he reported having chest pain, which he thought was normal. The nurse evaluated his pain, determined it wasn't normal, and made an appointment with his physician, who adjusted the medication, potentially preventing a readmission down the road.

Another patient who had a surgical procedure reported running a fever several days after discharge. The Nurseline nurse got the woman an appointment with her physician immediately and it was determined that she had a postoperative infection.

If the Nurseline nurses feel it's needed, they make an appointment for the patient to see their physician. In some cases, they call the physician and ask for a home health visit if the patient is homebound or doesn't have transportation.

Patients who are designated high acuity may be those on multiple medications who seemed confused about which to take when. They may live alone in a rural area or be someone who has had frequent readmissions.

"This is a transitory town. We have a lot of seniors who don't have family around. The nurse line gives us a checkpoint to make sure they're safe and understand their discharge instructions," she says. ■

Joint Commission issues timely disaster report

The Joint Commission on Accreditation of Healthcare Organizations has issued Standing Together: An Emergency Planning Guide for America's Communities, a step-by-step guide for small, rural, and suburban communities to prepare for and successfully respond to major local and regional emergencies.

An all-disaster planning approach addresses hurricanes, floods, terrorist attacks, major infectious outbreaks, hazardous materials spills, or other catastrophic occurrences. Though certainly timely, the planning guide is the culmination of a two-year project funded by the Illinois Department of Public Health, the Maryland Institute of Emergency Medical Services Systems, and the National Center for Emergency Preparedness at Columbia University.

13 essential steps

The comprehensive planning guide provides 13 essential steps that local government and public health leaders can use to establish an effective community-based emergency management planning and response process. These steps acknowledge that small communities face a number of significant barriers to emergency readiness, such as uncertainty about who is responsible for planning, how to fund emergency readiness efforts, what exactly constitutes the planning and response processes, and how to coordinate with state and federal emergency management resources.

In the new guide, strategies for and examples of each component are geared to small, rural, and suburban communities. The component steps are to:

1. define the community
2. identify and establish an emergency management preparedness and response team
3. determine the risks and hazards the community faces
4. set goals for preparedness and response planning
5. determine current capacities and capabilities
6. develop the integrated plan
7. ensure thorough communication planning
8. ensure thorough mental health planning
9. ensure planning related to vulnerable populations
10. identify, cultivate, and sustain funding sources
11. train, exercise, and drill collaboratively
12. critique and improve the integrated community plan
13. sustain collaboration, communication, and coordination ■

(Continued from page 166)

helping the hospital treat and identify community services for the tremendous influx of patients coming from New Orleans.

The social workers spent some of the first few days in the emergency department (ED), helping people who were being discharged find a place to go and assisting them in locating family members so the ED staff could concentrate on treating patients. It was then staffed by the outpatient mental and behavioral health team because the greater need was for the social workers to be on the acute units, Tilley says.

The case managers spent their time at the bedside and in the ED, helping take care of patients. They helped staff a special triage area for patients being transferred from other hospitals.

"When patients came in from other hospitals, the case managers and nurses assessed them, got a physician, and admitted them straight from there," Tilley says.

The hospital set up a prescription writing area, staffed by nurse practitioners and physicians where people who needed only a medication refill could get prescriptions.

Some patients who were transferred to the hospital came with a makeshift medical record. Others came from the special needs center with just a triage form.

About a dozen patients, mostly infants with heart problems, were transferred to Our Lady of the Lake from Children's Hospital in New Orleans along with their entire record. They were accompanied by nurses and a pediatric heart surgeon.

"Some were airlifted, some came by ambulance, and others were brought in their car by their parents who were desperate to see that their children got care," Tilley says.

Our Lady of the Lake and other Louisiana hospitals go on disaster alert every time there's a hurricane in the Gulf of Mexico, whether it's aimed at Mississippi or Pensacola or Louisiana.

The day before Hurricane Katrina was expected to hit, the disaster plan went into effect. The hospital leaders and department heads made arrangements to stay at the hospital and urged their staff to do so as well.

The hospital set up a child care center in the auditorium for children of employees and accommodated the staff as much as possible.

A command center headed by the administrator on call operated 24 hours a day and coordinated communications with the Louisiana Office of Emergency Preparedness (OEP) and the Louisiana Hospital Association, which coordinated the transfer of patients from other hospitals.

Patient care services sets up an employee pool of nonclinical staff to help with the telephones and other duties, freeing up the clinical staff to care for patients.

Every two hours, the hospital called the OEP to let them know how many beds and what kind of beds were available.

Transferring hospitals also called the OEP to see what beds were available for their patients.

The federal law mandating that hospitals have to take any patient that presents was suspended for the first 72 hours following the hurricane, allowing the hospital to send patients with less serious needs to other cities.

"We had all these systems in place for Katrina, but as much as we prepared, the hospital was simply overwhelmed by the influx of patients," Tilley says.

After the arrival of storm evacuees began, case managers in the managed care department e-mailed the payers, notifying them that the case managers were working at the bedside and in the ED taking care of patients and wouldn't be able to conduct utilization reviews in the days following the storm. Nurses from the revenue management department helped during the first week, doing utilization review as needed.

A number of patients transferred from New Orleans had insurance from companies that do not contract with Our Lady of the Lake. Those insurers agreed to pay the bill.

More than three weeks after the hurricane hit, the hospital's business office had begun the arduous task of backtracking to determine what kind of insurance coverage the patients they treated had.

The hospital never lost power during the hurricane, although a hospital-owned nursing home two blocks away lost power for two days and many staff ended up spending the night at the hospital because their homes had no power.

The hospital's capacity is 600, with a normal census in September of 450. Three weeks following the hurricane, the census was 570.

"In the weeks after the hurricane, we rescheduled all the elective surgery that was postponed so we could take care of the patients coming from New Orleans. The hospital is still feeling the effects and trying to catch up," Tilley says.

(Editor's note: Lesley Tilley may be contacted at: ltilley@ololrmc.com.) ■

ACCESS MANAGEMENT
QUARTERLY

System aims to improve patient throughput

3 hospitals have different issues, different strategies

Providence Health System is pulling out all the stops as it focuses this year and next on improving patient throughput at its three Portland, OR-area hospitals, says **Kathy Campbell**, black belt project manager for health services integration.

In June 2005, Campbell says, she assumed a leadership role in answering the question, "How do we improve our process so that we put the right patients in the right beds at the right time?"

A key part of the effort — but by no means the only tool being employed — is the quality assurance and process improvement strategy known as Six Sigma, which has teams led by people who have been trained as "black belts" or "green belts" in the organization.

The Hospital Flow Diagnostic, an electronic tool offered by the Cambridge, MA-based Institute for Healthcare Improvement (IHI) for measuring hospital throughput and activity based on bed turns, also will be used, Campbell adds.

Each of the three hospitals is doing different things to achieve throughput improvement, because the root cause of the problem might be a little different at each facility, she notes.

Patient throughput, or the efficient use of inpatient beds, is one of three principal areas being targeted this year by Providence Oregon, says **Nancy Roberts**, regional director for integrated performance/Six Sigma champion. Other areas of focus are labor productivity and patient safety.

An organizationwide initiative called "Operational Excellence," meanwhile, is the thread that runs through all the efforts to "make us efficient, excellent at the work we do," she adds.

"Our Operational Excellence strategies and tools are there to help us achieve our long-term goals," Roberts adds.

With the growth in the community served by the health system has come a large number of under- and uninsured people who make throughput improvement especially important, she points out. "We have a mission to serve the poor and vulnerable, so we need to be as streamlined as we can, so we can fulfill our mission."

There currently are four Six Sigma projects that are aimed specifically at improving throughput, adds Campbell, who described them as follows:

• **Length of stay (LOS) for orthopedic patients discharged to skilled nursing facilities (SNF).**

Patients on the eighth-floor east orthopedic unit at Providence St. Vincent Medical Center who had hip procedures and had to be discharged to an SNF were found to have a longer LOS than patients discharged home (5.01 vs. 2.45 days), she says.

Facilitating the timely and appropriate transfer of these frail patients, Campbell notes, not only will allow the hospital to better meet patient and family care needs and improve hospital divert times, but it is expected to have a positive financial impact of between $350,000 and $500,000 annually.

The project focuses, among other things, on identifying those patients early in the process and building preprinted order sets around caring for them, she adds.

It has identified a number of factors that can be used to predict LOS variation for these patients, including the day of the week when admission, surgery, and discharge occur; the timing of acute care manager and occupational therapist orders; and when the transfer form is completed.

The goal of the project is to reduce LOS for those patients to an average of 72 hours and a maximum of 84 hours.

While that project employs the extremely data-driven techniques of Six Sigma, Campbell points out, a project on the other end of the eighth floor focuses on communicating with patients at the point of admission about discharge planning.

Those conversations have to do with the expected LOS, whether a certain type of stay

might require discharge to another setting or home care service, she says.

Another big piece of the project is working with physicians and nurses to get them to be more efficient at writing discharge orders, adds Campbell.

A third piece is encouraging physicians to do rounds first with patients who are ready to be discharged, rather than the traditional practice of going first to the more critically ill individuals, she says.

This project is people-driven, rather than data-driven, Campbell notes. "Sometimes Six Sigma fits, and sometimes it doesn't."

• First-case surgery patient in operating room (OR) on time.

The second Six Sigma project has to do with smoothing out surgery schedules by ensuring that the first surgery case is in the OR on time, she continues. "The premise is that things get backed up during the course of the day because they don't start on time."

In 2004, 44% of first-case surgery patients entered the Providence St. Vincent OR early or on time, Campbell notes. The goal is for 75% of elective first-case surgery patients to enter the OR early or on time.

The strategy for streamlining the surgery flow was to make sure there were enough beds for scheduled cases and enough surgery time for the "uncontrollable variation" that comes through the door, she explains.

There now is a ready room available for those emergency cases so the schedule doesn't back up, Campbell adds.

• Providence Portland emergency department (ED) to floor transfer.

The third Six Sigma throughput project focuses on improving patient flow to get patients out of the ED or cared for more appropriately while there, she says.

"We spend a fair amount of time on divert because we can't get certain types of patients out of the ED," Campbell explains. The goal of this project, which is at Providence Portland Medical Center, is to shorten the length of time it takes to get a patient from the ED to the nursing floor.

"They were finding that once they elected to admit a patient, it was taking an hour, on average, to actually get them into the bed," she notes. "They're working to identify the reasons for the backup and what they can do to improve that."

The goal, Campbell says, is to reduce the time between ordering the inpatient bed and the patient leaving the ED to 30 minutes.

CE *questions*

20. Spartanburg Regional Healthcare Center has begun using college-prepared staff to assist their nurse case managers. What are they called?
    A. Case management assistants
    B. Care management extenders
    C. Health management extenders
    D. Case management associates

21. At Good Samaritan Hospital in Baltimore, what is the role of the support person?
    A. Faxing in insurance information
    B. Ordering durable medical equipment
    C. Arranging patient transportation
    D. Following up on tests and other barriers to discharge

22. As their hospital was deluged with evacuees from Hurricane Katrina, how many hours a day did the case managers at Our Lady of the Lake Medical Center in Baton Rouge, LA work?
    A. 12 hours
    B. 15 hours
    C. 20 hours
    D. 10 hours

23. Following a process improvement initiative at St. Luke's Health System, what percentage of patients with community acquired pneumonia were given antibiotics within the recommended four-hour interval after admission?
    A. 75%
    B. 42%
    C. 86%
    D. 90%

Answer key: 20. C; 21. D; 22. A; 23. 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 **December** 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. ■

'Bed turn' is at the heart of IHI throughput tool

While Providence Health System has used such methods as measuring length of stay (LOS) and focusing on "discharge by 11" to improve patient throughput, a recent Institute for Healthcare Improvement (IHI) "call around" offered some new food for thought on the subject, notes **Kathy Campbell**, black belt project manager for health services integration.

The call, billed as "What senior leaders need to know about flow," essentially covered an electronic tool that can be used to diagnose an organization's throughput problems, she says.

The tool, known as the Hospital Flow Diagnostic, focuses on "bed turn" as a method for measuring hospital throughput and hospital activity, Campbell says. Bed turn, she adds, can be looked at both with and without adjustment for acuity based on the case mix index.

"[IHI says] the preferred method is to measure bed turn, and when you collect the data, run it through an algorithm," Campbell says. "That tells you whether you have significant delays due to high demand, significant delays due to inefficient use of capacity, or significant delays due to high LOS adjusted for case mix."

After determining whether the problem is LOS-related, there are too many patients who want the beds, or capacity is not being used appropriately, she adds, a facility can focus improvement efforts around its specific issues.

(Editor's note: More information on the IHI throughput diagnostic tool is available at its web site: www.ihi.org.) ■

"Achieving that reduction on 15% of nonpsychiatric ED patients will more than accommodate a planned admission increase of 406 inpatients, which equates to $1,055,600 in revenue," she adds.

• Stroke unit process improvement.

The fourth Six Sigma project concerns the 350 stroke patients treated each year at Providence St. Vincent, 42% of whom have a LOS longer than four days, says Campbell, who notes that work flow inefficiencies cause delays in discharging some stroke patients who are medically ready for discharge.

The goal for this project, she adds, is a 50% reduction in the percentage of stroke unit patients with a LOS of more than four days. The resulting increase in bed capacity on the unit, Campbell says, will allow more stroke patients to be placed there, as opposed to being placed in other hospital units or extending their stay in the intensive care unit.

One of the other initiatives happening in the ED has to do with finding a streamlined way to communicate when the facility needs to go on diversion status, she says. Typically, the access department or the nursing units might learn that the ED is on divert, but they might not know the reason.

"A Providence research analyst built an electronic means of entering the information and a way to send it out to the key folks, so we know why we're on divert and what we can collectively do as managers to get off divert," Campbell says.

Another initiative related to LOS, she notes, has to do with its link to secondary behavioral health problems.

At Providence Portland, a nurse practitioner who specializes in behavioral health will be developing a role in which she can support the nursing staff as they deal with patients whose conditions do not fall within the guidelines of mental illness, but whose behavior is interfering with their ability to be discharged. "Nurses who don't primarily work with mental health patients may not have the skills to deal with behavioral issues, like noncompliance, that might keep patients from being discharged," Campbell says.

Rather than being patient-centered, this project is about the nurse practitioner educating nurses in medical-surgical areas, "teaching them to fish," so they can better address these special needs, she explains.

Campbell's intention as she leads the throughput effort is to develop a high-level strategy to tie together operational and administrative improvement objectives. The next step will be to "build tactics for the subcategories to be in line across the board and get a result," she adds.

"One of the things I've heard recently is that [organizations] can get too many projects going, and many of them get diluted," she explains. "Sometimes, different divisions are tackling the same problem and we don't necessarily do a good job of lining up the operational folks with the administrators who oversee the programs.

"From past experience, I know that [operational staff] have priorities that are coming in from various areas in the organization," Campbell says. "When you're the lowest-level staff responsible for filling those [needs], you know you can't do it all. You have to push some things aside and figure out who's going to scream the loudest.

"We need to do a better job of prioritizing and

linking those [objectives] together," she adds.

*(Editor's note: **Kathy Campbell** can be reached at kathy.campbell@providence.org. **Nancy Roberts** can be reached at nancy.roberts@providence.org.)* ■

'Operational Excellence' employs new techniques

Six Sigma, CAP used at Providence

Under the banner of a comprehensive initiative called "Operational Excellence," employees at Portland, OR-based Providence Health System are working to help their organization meet its strategic goals, says **Nancy Roberts**, regional director for integrated performance and Six Sigma champion.

Access issues — including projects aimed at reducing outpatient wait times and enhancing patient throughput — have played a prominent role in the process improvement effort, she says.

Key among techniques being used to improve the efficiency and effectiveness of its business and clinical processes is the quality improvement and process-improvement strategy Six Sigma, Roberts explains. "Many times [to solve a problem] you gather people in a room and say, 'What do we need to do?' That's the expert-driven approach. In Six Sigma, you might start there, but then you look for data to support what you need to do."

A methodology with its roots in the manufacturing industry, Six Sigma has been used in health care only in the past six or seven years, she says. "It's a very vigorous [methodology] to reduce errors in any kind of process. The key elements are the strong use of data to drive decision making and that it's very customer-focused."

Using the concepts "define, measure, analyze, improve, control," commonly referred to as DMAIC, Six Sigma works "in quite a linear way," Roberts explains. "Six Sigma is helpful in analyzing existing processes to find why they're not producing the desired results and analyzing data to determine what you need to fix."

At the same time, Providence is using a change management tool that is designed "to help organizations be better at incorporating and implementing short-term and long-term effective change," she adds. "We've meshed it together with our use of Six Sigma."

Although it's easier to get results in the early phases of a project "when there's a lot of attention on it, a lot of monitoring," Roberts points out, the challenge is in maintaining the change over time.

Providence is using a change management tool from General Electric called Change Acceleration Process (CAP), but there are a number of others available, she says. "Basically, the theory behind CAP is that in order to effectively move to an improved future state, both people and teams need to work through stages."

It's about "creating a shared need" by asking "Why do we need to change?" and shaping a vision by asking "What does the future look like?" she adds.

"You make sure people are getting feedback on how the new world is working, and some of it is control charts and graphs," Roberts says. "We are, in fact, doing this, and it is having the impact we wanted."

Unlike Six Sigma, she notes, "the CAP model is not linear. You can loop back around when you're doing change management work." ■

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. ■

COMING IN FUTURE MONTHS

- Case management's role in reporting medical errors
- How you can help with your hospital's disaster plan
- Ways you can prove the value of your case management efforts
- Extending the hospital's walls into the community

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2005 SALARY SURVEY RESULTS

HOSPITAL CASE MANAGEMENT™

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

Salaries are up, but CMs are putting in long hours

Nursing shortage presents challenges, advantages

Salaries for case management are increasing, but the vast majority of case managers are working far more than the traditional 40-hour week and in many cases are being asked to be more than ever before, according to respondents to the 2005 *Hospital Case Management* Salary Survey.

The 2005 Salary Survey was mailed to readers of *HCM* in the June issue. More than half the respondents (57%) were case management directors. Other respondents were case managers, utilization managers, social workers, or had other titles.

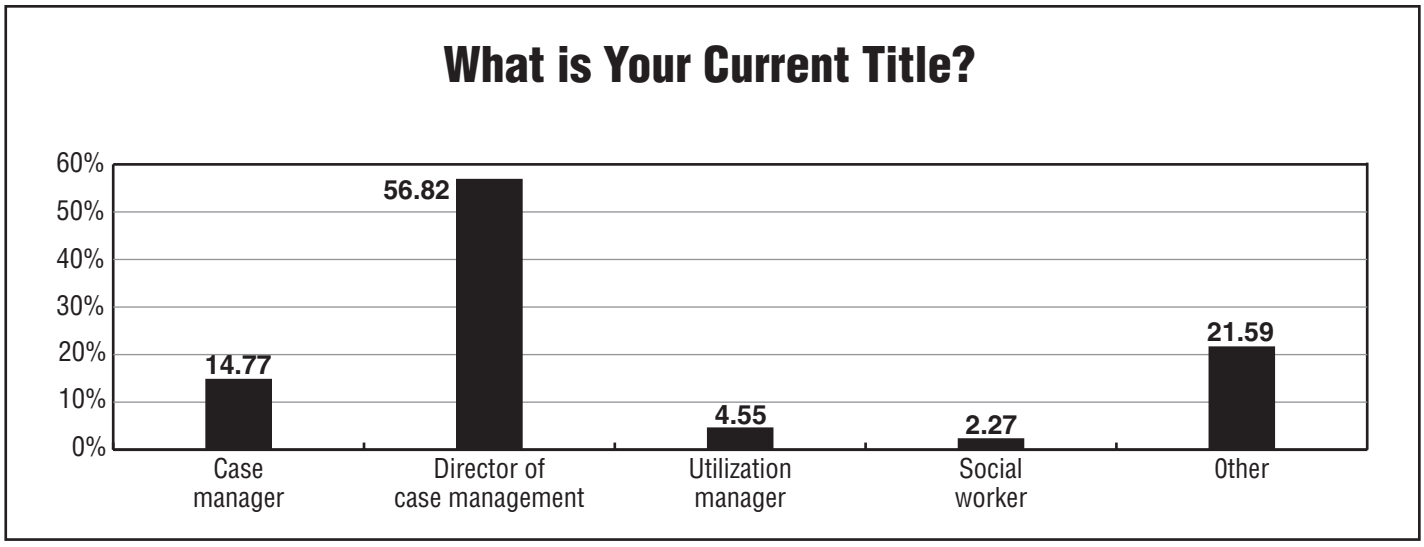
The increase in salary is bolstered in some instances by the nursing shortage as hospitals raise nursing pay levels, and case management salaries along with them.

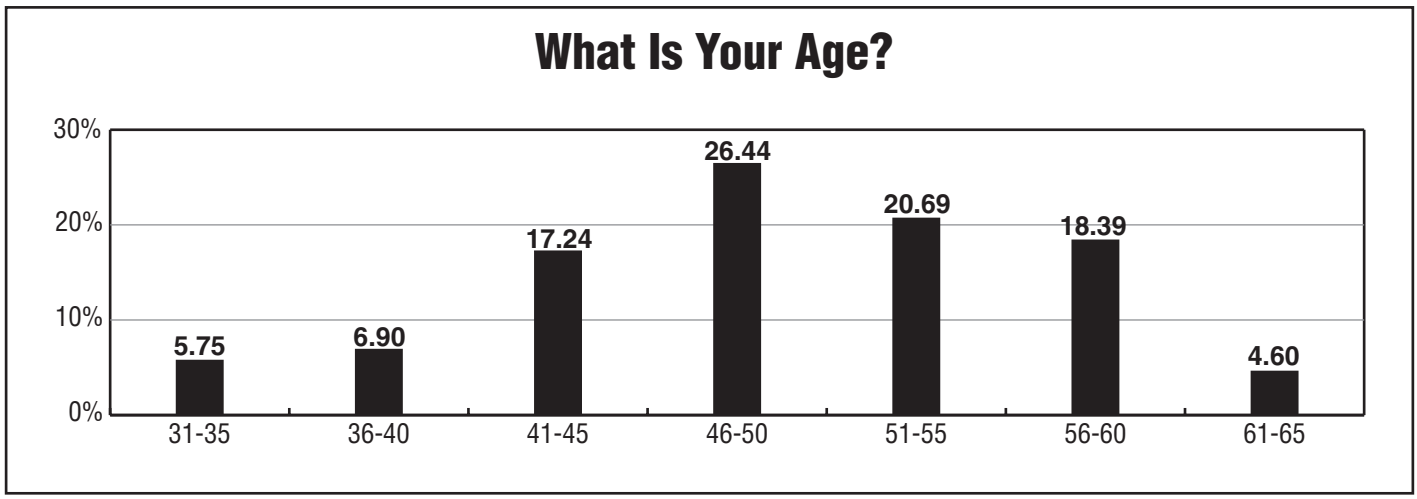
For instance, at St. Vincent's Medical Center in Jacksonville, FL, the care managers are paid at the same level as a position comparable to an assistant nurse manager.

"We don't have a problem filling care manager positions because of the pay levels. Over the years, because of the competitive nature of nursing salaries within our region, the case management pay has risen in keeping with the nursing rate," reports **Jamie Zachary**, LCSW, director of case management.

At St. Vincent's Medical Center, the average merit increase for case managers was 3% last year, but a recent adjustment in nursing salaries equaled a 10% increase. Benefits have remained the same in recent years.

Respondents to the survey report putting in





long hours. In fact, almost 95% report working more than 40 hours a week, with more than 25% working more than 50 hours a week, up from 18.5% in the 2004 survey.

At the same time, 89% of respondents reported an increase in salary during the past year, about the same as respondents to the 2004 survey. The highest percentage (48.3%) reported getting a 1% to 3% raise, followed by 29% whose salary increases were between 4% and 6%, and nearly 9% who received raises of 5% to 10%. Only 11% reported no increase or a decrease in salary.

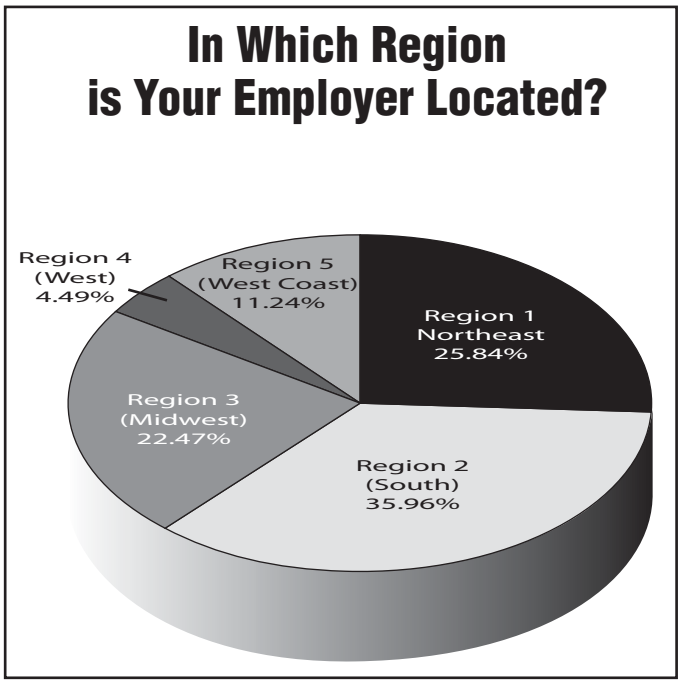
About 68% of respondents to the survey report salaries in the $60,000 to $99,000 range, with nearly 9% reporting salaries in excess of $100,000 and 23.6% reporting pay of $60,000 or less.

At the same time that salaries have risen, requirements for case managers have increased, says **Mindy Owen**, RN, CRRN, CCM, principal of Phoenix HealthCare Associates LLC, a Coral Springs, FL-based consulting firm specializing in case management, disease management, and managed care development and education and chair of the Commission for Case Manager Certification.

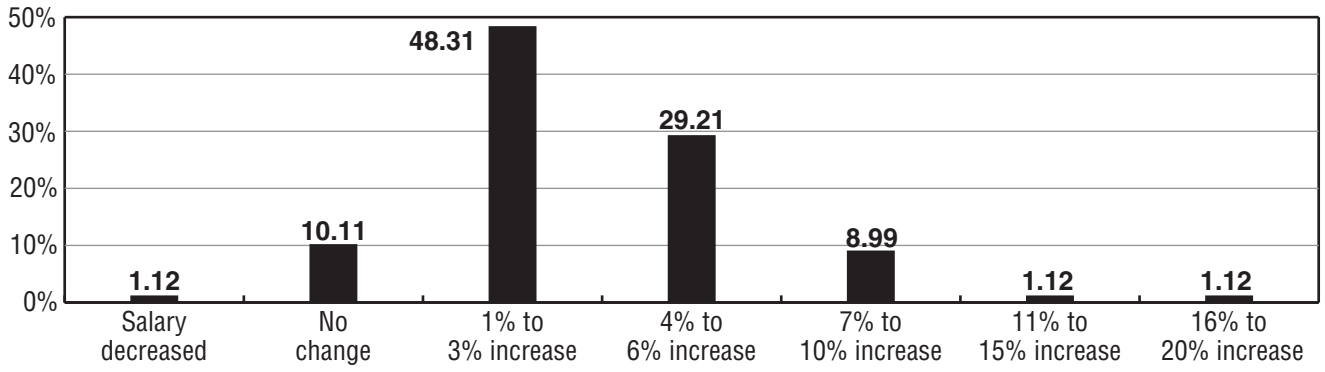
Most hospital nurse case manager jobs require three to five years of clinical experience, familiarity with computers and software, some managed care or HMO experience, and excellent interpersonal skills, Owen says.

Among respondents to the *HCM* Salary Survey, nearly 58% have 25 years or more experience in health care, with 47% of respondents reporting that they have worked in case management for 10 years or more.

Case managers are being called on to work evenings and weekends, and the role of case



In the Last Year, How Has Your Salary Changed?



managers has expanded in many hospitals to include utilization review, discharge planning, and denials management — roles that in the past may have been delegated to staff in other departments.

Care management staff at St. Vincent's are in the hospital from 7 a.m. to 1 a.m., seven days a week.

Weekdays are filled by full-time salaried staff, with part-time staff working in evenings and on weekends.

"Prior to 2002 when we hired people specifically for weekends, the staff had to rotate, and it was hard on morale," Zachary says.

While the nursing shortage has presented increasing challenges to hospitals in recent years, the effects on case management departments have been limited, case management directors report.

In fact, the nursing shortage has brought more nurses to the case management arena as a career option as nurses are opting out of the clinical role and moving to other positions, Owen says.

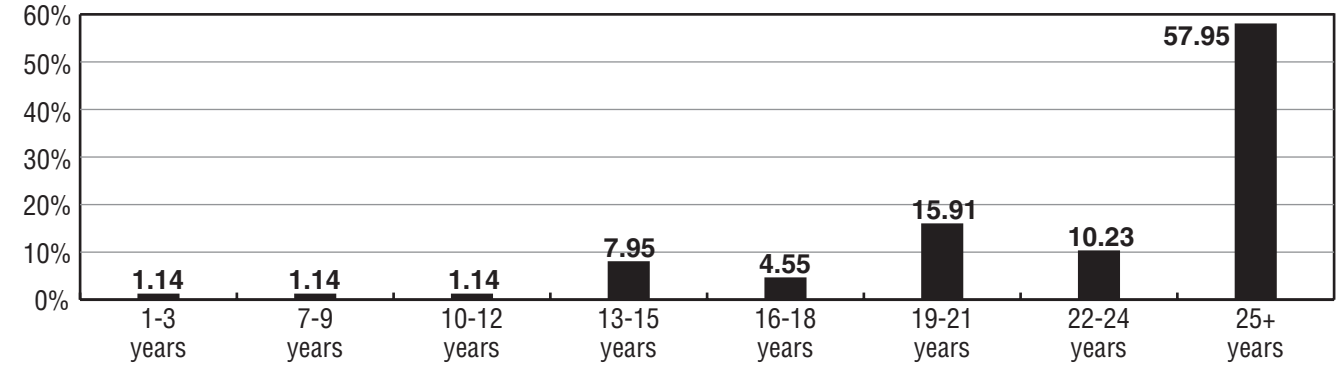
"Nurses on the floor are expected to handle more and more responsibilities. Their frustration level has risen because they are stretched so thin they can't do the job they want to do and feel they should be doing in a clinical setting," she says.

In a way, the nursing shortage has led to increased compensation for case managers as hospitals raise the level of nurses' pay. In large medical centers, case managers usually rank at the assistant nurse manager level or higher, with a corresponding bump in salary, Owen says.

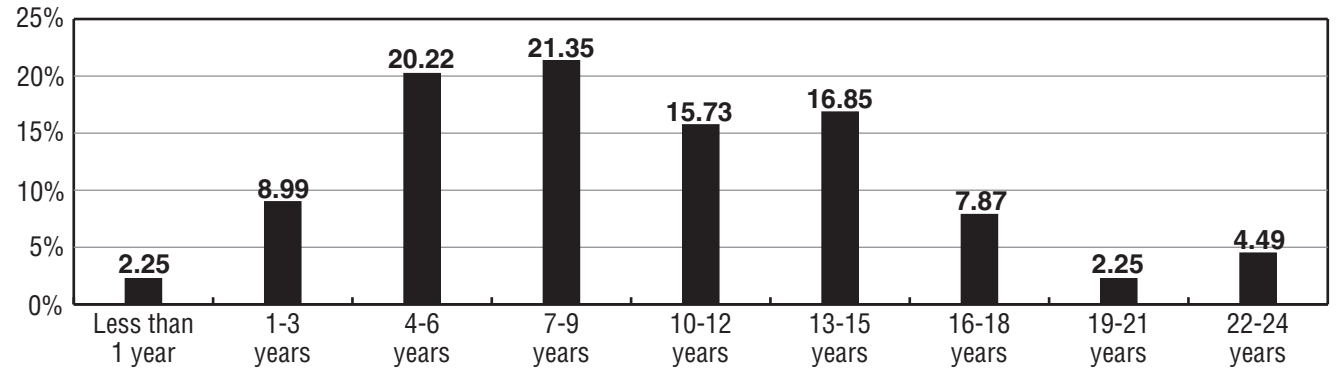
Some hospitals are supplementing or replacing regular merit raises for staff with some form of compensation that is based on setting and meeting measurable goals, says **Steve Blau**, LCSW-C, director of case management at Good Samaritan Hospital in Baltimore.

"The trend is to go toward an incentive arrangement vs. steep changes in the base pay.

How Long Have You Worked in Health Care?



How Long Have You Worked in Case Management?



Instead of a traditional merit raise, more hospitals are looking at pay for performance and basing increases on meeting goals and objectives," he says.

Blau has created a five-point scale for his employees, setting goals that include opportunities for bonuses and raises. The majority of the goals are team-based goals with raises tied to the outcome.

The goals depend on the hospital unit and the duties of the staff. For instance, some are based on inappropriate admissions, denials, or lengths of stay. Several of Blau's colleagues at other hospitals have told him of risk-sharing arrangements in which a case management director agrees to a lower base salary with an opportunity to get a bigger bonus at the end of the year.

"If a case management department brings in $600,000 of denied-day overturns, case management directors may be inclined to ask for a percentage," he says. This trends points up the importance of case managers tracking outcomes and being able to show that they are affecting the bottom line, Blau adds.

"The goal is to continuously show the value of case management. If you have a good system of data collection and can translate it to show how much the case managers saved the hospital by reducing length of stay, this puts you in a position of strength, rather than just saying the staff is really working hard," he says. ■

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