HOSPITAL CASE MANAGEMENT™

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

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

Financial Disclosure:
Managing Editor Russ Underwood, Editorial Group Head Coles McKagen, and Editor Mary Booth Thomas report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Toni Cesta discloses that she is principal of Case Manager Solutions LLC.

JANUARY 2006
VOL. 14, NO. 1 • (pages 1-16)

Physician advisors can help case managers do their job better

Rely on them to intervene when problems arise

If you aren't taking advantage of the assistance your case management physician advisor can offer, or if you don't have an advisor, you may be missing opportunities to move patients safely and efficiently through the continuum of care.

Case management directors who work closely with their physician advisor find that the help is invaluable in helping the attending physicians understand coding, admission criteria, and the importance of getting tests and consultations completed and the patient ready for discharge in a timely manner.

"Our physician advisor is always available to me and the case managers at all hours. If they foresee a problem with a denial or length-of-stay issue, they can contact him immediately and not wait until the next day. It's been a tremendous help in cutting down on denials and avoidable days," says **Marilyn Butler**, RN, MS, CCM, director of case management at Southern Ocean County Hospital in Manahawkin, NJ.

In many hospitals, case managers and their physician advisors work as a team to address issues that may include length of stay, compliance with the Centers for Medicare & Medicaid Services (CMS) Core Measures, following clinical pathways, and educating physicians on the role of case managers.

"There are so many opportunities to educate physicians. They don't come out of medical school knowing about case management, and the more they know about it, the more likely they are to be on board. I tell them that we want to be part of their efficiency and to work together to

improve patient satisfaction and quality outcomes," says **David L. Gormsen**, DO, FACEP, chief medical officer and physician advisor to case management at Mercy Medical Center in Canton, OH.

Case managers can call on their physician advisors to intervene to assure that patients meet continuing stay or admission criteria.

"As soon as the case managers feel that a patient is not appropriate under Interqual criteria, they get in touch with the resident or the attending physician. They have a right to ask them questions, and if the physicians don't answer the case manager's concerns, I get involved," says **Minal Shah**, MD, physician advisor to case management at Northshore Hospital at Forest Hills, NY.

Physician advisors also can be helpful when it comes to educating the administration about what the case managers do, how much they contribute to the success of the hospital, and in ensuring that the department gets appropriate support. "This means communicating with the top administration. I do that through a quarterly meeting with the executive staff. I always give a synopsis of the initiatives we are working on and what successes we've seen," Gormsen says.

Hospital Case Management looked at the different ways case managers work with their physician advisors. Here's what we found:

At Southern Ocean County Hospital, the case managers and medical director work as a team to reduce denials and avoidable days and ensure that the patients get timely and efficient care, says **Sekander A. Ursani**, CPE, MD, medical director.

Ursani makes daily condition rounds with the case managers, social workers, and nursing staff on each unit and attends managed care rounds once a week, during which he meets with all of the case managers and social workers to discuss patients covered by managed care plans.

"Together, we have done good things for the hospital. We've reduced length of stay, reduced the denial rate, and improved patient care. I could not do it without the case managers who are my eyes and ears, and it's not something they could do on their own," Ursani says.

The team on each unit conducts concurrent reviews of cases on a daily basis to make sure the patient meets criteria to remain in the hospital.

"The nurses and case managers are very adept at recognizing when a patient should stay in the hospital or when they're ready for discharge. They recognize it and tell me," Ursani says.

In addition, Ursani encourages the case managers to call him at any time to discuss a case, even when he's not on site. For instance, a case manager recently called Ursani with concerns that a patient no longer required a hospital level of care. Ursani reviewed the case with the case manager, spoke with the attending physician, and got him to discharge the patient, preventing an avoidable day.

"The case managers are very skilled. They flag the chart and write notes to the attending

Hospital Case Management™ (ISSN# 1087-0652), including **Critical Path Network**™, is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Case Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 Mon.-Thurs.; 8:30-4:30 Fri. EST. E-mail: ahc.customerservice@thomson.com. Web site: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $469. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $78 each. (GST registration number R128870672.)

Thomson American Health Consultants is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, provider number CEP 10864. This activity is approved for 18 contact hours. This activity is valid 36 months from the date of publication. This program is approved by the American Association of Critical-Care Nurses (AACN) for 14 contact hours. Provider (#10852).This activity is approved by the Commission for Case Manager Certification for 18 clock hours.

Editorial Questions

For questions or comments, call **Russ Underwood** at (404) 262-5521.

Editor: **Mary Booth Thomas**, (marybootht@aol.com).
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@thomson.com).
Senior Production Editor: **Nancy McCreary**.

physicians, stating their concerns. If the attending physician doesn't respond, the case managers call me," Ursani says.

The case managers alert Ursani if a case has the potential to be denied, and he appeals the cases concurrently.

"I take the case managers' notes and supplement them with what I know as a physician, then talk to the medical director of the health plan. We've been successful in overturning a significant number of denials through concurrent appeals," Ursani says.

In addition to a medical advisor who works with the entire case management department, Hackensack (NJ) University Medical Center has team physicians who attend daily multidisciplinary rounds on patient care units and act as mentors for the team members, including case managers.

Some of the team physicians are on the medical center staff. Others have individual practices and volunteered to work with the team.

"We start the morning by looking at the patient's plan of care. Having a rounding physician there allows us to deal with the issues on the spot," says **Pat Eason**, RN, BSN, administrative director, case management services.

For instance, if a patient's test results are back, the rounding physician can call the attending physician with the results and get additional treatment started in the morning, rather than after the attending physician comes in the afternoon.

The physician advisor to the entire case management department takes care of questions and concerns that come up after the morning rounds. When he comes in each day, he goes to the case management office and gets a list of the case managers who have requested his assistance and goes to their units.

"We've had a physician advisor as long as there has been a case management department. The role has evolved and become a lot stronger in recent years," Eason says.

At Mercy Medical Center, Gormsen meets with the case managers and social workers once a week to discuss whatever issues the staff want to bring up. They go over each individual case, determining how it should be handled and who should handle it. If there is a trend, the team looks further, says **Paula Benson**, RN, BS, manager of case management. **(For details on their initiatives, see related article on p. 4.)**

On occasion, the team invites other hospital staff if there is an issue pertinent to their role. For instance the vice president of managed care is involved when a denial needs to be appealed to a higher level.

When case management staff review cases for appropriate admission or length of stay, they initially intervene with the physician. If they are having difficulty with a physician or a family, they turn the case over to Gormsen.

The case management department has a referral form it faxes to Gormsen's office. He goes to the floor and talks to the case managers about the case, reviews the chart, and talks with the physician or family.

"It's a collaborative thing. Clearly, when case managers haven't had success, I call the physician involved. I don't always agree with what they're doing, but it's still their choice and their patient," he says.

Here are some tips from physician advisors on how to make the role work in your hospital:

• Choose a physician who is interested in taking on the role of physician advisor and wants to make it successful.

"The role does take time. Sometimes it's a matter of making several phone calls a day, or I might need to make rounds on the floor that day. It depends on what's going on in the hospital," Gormsen says.

• Make sure your hospital's administration realizes how important a physician advisor is for its success and is willing to compensate him or her for it.

"Once the administration realizes how important a physician advisor is, that's half the battle," Gormsen adds.

• Choose a physician advisor with no conflicts of interest.

"Physician advisors should not be practicing physicians who depend on other attending physicians for referrals," Ursani suggests.

• When you refer a case to your physician advisor, be as accurate and complete as possible and include all the information he or she will need to review the case.

"The type of information they include for my review is the key to success, and it's what separates the good case managers from those who are not so good. If I have specific information, it cuts my time in half," Shah says.

*(For more information, contact: **Pat Eason**, RN, BSN: peason@humed.com; **Marilyn Butler**, RN, MS, CCM: mbutler@soch.com; **Paula Benson**, RN, BS: paula.benson@csauh.com)* ■

Physician-case manager team cuts LOS, denials

Collaborative effort focuses on top 10 DRGs

By working as a team, the physician advisor and case management staff at Mercy Medical Center in Canton, OH, have decreased Medicare length of stay, cut managed care denials dramatically, and made physicians aware of the cost to the hospital of inpatient services that could be done on the outpatient side.

As a result of their initiatives, Medicare length of stay has decreased from 6.83 days in 1998 to 5.07 days in 2004. The hospital's denials consistently have been below 2% since 2001 and were at 0.8% in 2004.

The managers of case management and the director of quality management meet once a week with **David L. Gormsen**, DO, FACEP, chief medical officer and physician advisor to case management, examining the hospital's top 10 DRGS and focusing on the ones with the highest cost or length of stay.

They have developed physician report cards, comparing lengths of stay for patients in the hospital's top 10 DRGs and comparing the hospital's length of stay to benchmarks.

"We looked at why the length of stay was higher for some patients, such as were we having difficulty getting tests conducted or whether treatments were being ordered in a timely manner. Then we developed strategies to reduce the length of stay," says **Paula Benson**, RN, BS, manager of case management.

In one instance, a physician's patients had an extremely high length of stay in one DRG compared to his colleagues' patients. When Gormsen talked to him, he argued that his patients were sicker. The team reviewed the charts for his patient and concluded he was right — the patients were indeed sicker and belonged in a different DRG. His issues were lack of appropriate documentation to support the appropriate DRG.

In addition to focusing on individual cases, the team looks at educational opportunities for the attending physicians, such as inpatient MRIs and gastrointestinal (GI) work-ups that are not appropriate as an inpatient treatment.

For instance, the team focused on GI work-up at the end of chest pain observation.

"We met with the physicians to educate them that this is something that is not reimbursed and something that clearly could be done on an outpatient basis," Benson says.

When the case managers encounter an order for a procedure that can be done on an outpatient basis, they contact Gormsen, who calls the attending physician and suggests ordering the procedure as an outpatient test.

"One case may not make a difference, but they do add up and increase the overall length of stay," he says.

The case management department has worked with the finance department to put a dollar value on some of the most common procedures performed in the hospital that could be done on an outpatient basis.

"This has been the biggest eye opener for physicians. Any time you can save a lot of money, it's become very important," Gormsen says.

For instance, at Mercy Medical Center, performing an MRI on an outpatient basis instead of as an inpatient procedure saves $700.

"Major hospitals perform 100 or more MRIs each month on an inpatient basis. If they can do half as outpatients, they can save hundreds of thousands of dollars," Gormsen reports.

Physicians need to understand that if they do what is appropriate for their patients, it can add a lot of dollars to the hospital bottom line, he points out.

"If they help the hospital save that money, we can get them the state-of-the-art equipment they want, get the floors renovated, and make other capital improvements to help make their jobs easier," Gormsen explains.

Once a month, Benson and her staff create a "DRG of the Month" poster that is posted throughout the hospital to help focus staff's attention on best practices and recommended care for that particular diagnosis.

The posters list the hospital's length of stay versus the mean length of stay, the hospital's reimbursement vs. cost, and helpful hints for physicians on timely and appropriate care. For instance, the congestive heart failure DRG of the Month poster included:

- Are your patients on the pathway for congestive heart failure?
- Are they compliant with their treatment plan, or do they need support after discharge?
- Was the congestive heart failure coordinator involved in their discharge plan?
- If there was a consultation, was it ordered in a timely manner?

• Were comorbidities taken into account when the treatment plan was developed?

The team has promoted care plans for pneumonia patients that include getting patients started on IV antibiotics in a timely manner, resulting in a significant decrease in pneumonia lengths of stay.

With Gormsen's help, the team has been able to dramatically increase physician participation in appeals of denials.

"We don't have that many cases denied, but the chance of getting the denial reversed goes up if the attending physician gets directly involved in the appeal," Benson says.

When a treatment is denied, the case managers contact Gormsen, who enlists the help of the attending physician in the appeal.

They send letters of appreciation with a small gift certificate attached when the attending physicians come through for the team by calling the insurance company's medical letter or writing a letter if a denial for reimbursement is being appealed.

The hospital's case managers are assigned by unit and by the type of coverage a patient has. Three case managers handle all the managed care patients. There are 4.5 FTE case managers who coordinate care for Medicare, Medicaid, and self-pay patients. They conduct an initial assessment and find out the discharge needs or barriers to discharge. If patients need more follow-up and intensive discharge planning, the case managers refer them to the discharge planners. The discharge planners are all social workers with the exception of one LPN in that role.

This year, the hospital has assigned a case manager to the medical teaching service, helping the residents within the hospital better understand case management and length of stay. The case manager rounds with them every day and educates them about the goals of case management.

"They become a team right from the start. The residents start to understand how important they are in helping case management and the hospital achieve our goals," Gormsen says.

*(For more information, contact **Paula Benson**, RN, BS, at paula.benson@csauh.com.)* ■

Don't rely on Condition Code 44 to fix mistakes

Catch inappropriate admissions in advance

If your hospital is routinely filing claims under Condition Code 44, which changes a patient's status from inpatient to outpatient, your system for determining appropriate admissions may be failing.

"Hospitals today are really struggling with medical necessity issues, especially since CMS is focusing on one-day stays. Many hospitals, in their attempt to be compliant, as they understand it are using Condition Code 44 to prevent admission denials. They believe billing a lot of Condition Code 44 claims demonstrates compliance, but when a hospital frequently uses Condition Code 44, it indicates a failure to determine an appropriate level of care," explains **Deborah Hale**, CCS, president of Administrative Consultant Services Inc., a health care consulting firm based in Shawnee, OK.

Condition Code 44 was instituted by the Centers for Medicare & Medicaid Services (CMS) in 2004 and allows hospitals to convert inpatient admissions to outpatient admissions and file claims for Medicare Part B outpatient services under certain circumstances.

When the hospital determines that a claim is eligible to be submitted using Condition Code 44, the entire episode of care should be billed as an outpatient episode of care, as though the inpatient admission never occurred.

According to CMS, Condition Code 44 is appropriately used when a hospital's utilization review committee determines that an inpatient admission does not meet the hospital's inpatient criteria only when all of the following conditions as set out by CMS have been met:

• The change in patient status from inpatient to outpatient is made prior to discharge, while the individual still is in the hospital.

• The hospital has not submitted a claim to Medicare for inpatient admission.

• A physician concurs with the utilization review committee's decision.

• The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record.

The condition code allows hospitals to recoup reimbursement for some services when otherwise the bill for the entire episode of care could be denied. The only services the hospital can bill for under Condition Code 44 are some ancillary services that are listed in the *CMS Medicare Benefit Policy Manual.* Requirements for using Condition Code 44 are set out in Transmittal 299 from CMS.[1]

"Condition Code 44 is appropriate if the hospital

can meet the conditions set out by CMS in Transmittal 299, but I am seeing a lot of mistakes," Hale says.

Some hospitals are just changing the billing code to Condition Code 44 and not going through the utilization review committee process required by CMS, she adds.

Others are using it to convert from inpatient to observation status.

"Condition Code 44 does not allow you to convert from inpatient to observation status, only from inpatient to outpatient," Hale notes.

Here's an example of when Condition Code 44 is appropriate:

A patient comes to the emergency department after an episode of vomiting and is admitted to the hospital as an inpatient, even though there has been no attempt to manage the problem on an outpatient basis. The next morning, the case manager looks at the patient record and realizes that the patient did not meet criteria for admission as an inpatient.

The case manager should refer the case to the utilization review committee before the patient is discharged.

Rather than using Condition Code 44 to remedy inappropriate hospital admissions, hospitals should proactively catch inappropriate admissions at the point of entry before the services are delivered to the patient — and that's where the case managers come in, Hale says.

"Instead of trying to fix incorrect admission status using Condition Code 44, hospitals should use case managers to screen and evaluate patients based on the hospital's admission criteria. The initial decision about the site of service should be guided by case managers" she says.

Problems with the use of Condition Code 44 point out the necessity for having a case manager in the emergency department to help screen for appropriateness of admission and catch problems at the front end, rather than fixing them at the back end, she adds.

Most of the problems with improper admissions occur when the patients are admitted through the emergency department, Hale says.

That's why it is essential for hospitals to have case managers in the emergency department to make sure that any patients admitted to the hospital meet whatever admissions criteria the hospital uses, she adds.

Case managers also should monitor the surgery arena to make sure it is clear from the beginning which patients will have outpatient surgery and which will be admitted as inpatients. They should monitor direct admissions for medical necessity. In cases where it appears that the patient doesn't meet criteria, case managers should determine what factors might not be documented in the record and get additional documentation. If there is no additional information to support the necessity of admission, yet the patient cannot be managed in the home setting, the case manager should consider steering the patient to observation status, Hale says.

"The case manager's role includes educating physicians about appropriate levels of care," Hale points out.

CMS is monitoring the frequency with which that code is used and is working on an updated version of Condition Code 44, Hale says.

Reference

1. Transmittal 299 "Use of Condition Code 44: Inpatient Admission Changed to Outpatient" is available at www.cms.hhs.gov/manuals/pm_trans/R299CP.pdf. ■

Get involved in your insurance contracts

CMs' knowledge is invaluable in negotiations

If you're not involved when your hospital contracts with managed care companies, you may miss an opportunity to eliminate denied or avoidable days and maximize reimbursement.

"Insurance companies are scrutinizing claims more intensely, and they are adding a lot of penalties, more than we've ever seen before. This requires case managers to be more involved than ever before to make sure that the insurers' requirements are being met," says **Beverly Cunningham**, RN, MS, director of case management and health information management at Medical City Dallas Hospital.

Hospital case managers should be involved when the contracts are written or negotiated and should stay in the loop after the contract is signed so that they will be aware of any addenda the insurer makes that would affect the way they do their job, she adds.

Cunningham attends contract planning meetings and payer operations meetings as the division case management representative with her division of HCA.

"Managed care contracting staff need to talk to

*(See **Contracts** on page 15)*

CRITICAL PATH NETWORK™

Hospital's DM program cuts admissions, ED visits

Program saved $5 for every $1 spent

When Jackson Health System in Miami started its first hospital-based disease management program in 1995, the case management department was able to show that the hospital saved $5 for every dollar the hospital spent on case managers in the disease management program.

The first disease management program was for patients with diabetes. Now, approximately 30 case managers provide disease management for patients with a range of diagnoses including asthma, congestive heart failure, HIV-AIDS, obesity, hypertension, an employee wellness program, and behavioral health, in addition to the original diabetes program.

The goal of the hospital's disease management program is to support patients and their providers regarding their care to avoid hospital readmissions and visits to the emergency department (ED), according to **Abbe Bendell**, RN, CNS, MBA, CCM, vice president for care management, quality, and patient safety at Jackson Health System.

The hospital identifies patients with the potential for the disease management program by looking for chronically ill patients who are admitted frequently or who make frequent visits to the ED.

If a patient comes in with one of the diagnoses covered by the disease management program, the inpatient case manager alerts the outpatient disease management case manager to follow them on the outpatient side.

In some cases, the disease management process starts when the patient is in the ED. The ED case managers can refer patients directly to the disease management program, even if they are treated as an outpatient, ultimately avoiding an admission, Bendell says.

Depending on the diagnoses and the seriousness of the patient's condition, the disease management case managers may visit them in the hospital or be in touch by telephone after discharge.

The case managers offer their services to the patients, conduct an initial assessment, and arrange follow-up contact on the outpatient side.

"Even if the patients don't want a care manager who is closely in touch with them, we continue to monitor them from a distance to make sure they are getting their prescriptions filled and getting to their follow-up doctor's appointments," Bendell says.

The case managers who work in disease management visit the hospital's primary care sites at least once a week and work with the physicians and staff there to give the patient additional support.

They follow up by telephone to make sure the patients are following their treatment plan and periodically visit them in the clinic for a face-to-face visit. If the disease management case managers feel it's needed, they can visit the patient at their home or at another location.

Based on the patient's condition, the follow-up may be as often as once a week but, if the patient is stable, it may be as little as one a month or even less frequently.

"The frequency of the contact depends on the diagnosis and the case manager's ability to be in touch with the patient," Bendell says.

The frequency with which the case managers meet the patients in the clinic depends on the severity of the patient's disease and how frequently they are see in the clinic.

They coordinate with the treatment team to identify psychosocial issues that affect the disease process and any barriers to care.

When they visit patients in the clinic, the case managers may go into the treatment room with the patient, if the patient requests it, or visit with the patient after he or she has seen the doctor. They also talk to patients about the treatment plan, making sure they are taking their medication, exercising, and following an appropriate diet.

"They make sure that the patient has actually purchased the prescribed medicine. They talk with them to identify any problems at home, work, or school and look for any barriers to following the treatment plan," Bendell says.

They make sure the patient understood what the doctor said and identify whether he or she has additional educational needs.

The case managers look for barriers that might prevent the patient from accomplishing what the physician recommended and help him or her overcome the barriers.

"Sometimes the physicians give medication to patients that don't react well with the patient's system. More times than not, the patient won't tell the doctor this, and it's usually the case manager who figures it out," Bendell explains.

"Our goal is to help the client come to terms with his or her disease and to be able to manage it. We work to transition them back to their primary care sites without support from the case manager, although either the patient or the physician can call the case manager for support if the need arises," she says.

With some of the populations, the case managers may follow the patients for six months or a year and then refer them back to the primary care physician with little support. Other patients, such as those with HIV-AIDS, may require long-time disease management at frequent intervals.

A comprehensive educational program for patients with chronic diseases is a fundamental part of Jackson Health System's disease management programs.

The disease management case managers go into the community and conduct classes about chronic diseases in multiple languages. The educational program content was developed from best practices, such as the American Diabetes Association's recommended content for diabetes education classes.

The health system has created standardized educational materials that are used across the entire continuum of care.

For some patients, the educational process begins in the emergency department. The emergency department case managers have access to starter kits with information about the disease.

When a case manager determines that a patient needs more education following a clinic visit, he or she may present the education one-on-one on the spot or set it up for the patient to go to a class.

"Our education doesn't replace the chronic disease education that comes from the clinician. It's an overlay to the primary care physician's educational efforts. Most people need to be taught more than one time," Bendell says.

The hospital's disease management case managers are cross-trained to manage more than one disease, but the case managers with the most expertise in a particular disease act as a resource for the rest of the staff.

The health system's medical directors for each disease are another resource.

"When case managers have a concern about a patient and the care that is being provided, they discuss the case with the medical director for that disease. In some cases, the medical director gets together with the primary care physician on a consultation and may recommend a change in the treatment plan," she says. ■

Lean production efforts help save $7.5M in 1 year

Each service line has a dedicated director

Park Nicollett Health Services (PNHS), a health care system based in St. Louis Park, MN, has demonstrated savings of $7.5 million in 2004 as the result of adopting the Toyota Production System — also known as "Lean Production." The system's success stories include:

- reducing average patient waiting times at its St. Louis Park Urgent Care facility from 122 minutes to 52 minutes;
- increasing the number of phone calls answered within 30 seconds by 560%;
- reducing by 79% the cycle time between when a request is made to the organization's designated phone line for prescription refills to when the pharmacy receives authorization;
- reducing the number of medications prepared but not needed by 30%;
- decreasing the amount of paper phone messages filed in the paper medical record by 100%, as messages automatically become part of the patient's lifetime electronic medical record;

• processing 40,000 fewer surgical instruments per month, after analysis of variation in instrument preferences and agreement on standard instruments for each case.

• In the PNHS Cancer Center, patient flow improvements resulted in capacity for 10 additional chemotherapy and antibiotic infusion patients per day.

"Most of our focus is on our 'lean' efforts," notes **David Abelson**, MD, vice president of strategic improvement at PNHS, noting the "lean" move is about 2 to 3 years old. "This coming year, we will have 150 rapid process improvement workshops (RPIWs) — detailed examinations of processes used to find evidence of waste, develop standard work, and improve safety and efficiency); we have 7,000 people devoted to lean." Each service line, he explains, will have a dedicated "lean" director and three to four support personnel.

Abelson says lean production is significantly different from traditional continuous improvement methodologies, and even from the more recently popular Six Sigma. "Lean uses very specific principles on the best way to do work," he explains. "It's not just about continuous improvement but about CI using very specific principles for work, such as leveling the load; matching your capacity to demand; eliminating all different kinds of waste; pulling vs. pushing; making the work visible."

For example, he notes, two of the more successful improvements were focused around prescription refills and phone messages. "In both instances, we used the lean approach. The [RPIW] involves three weeks of prep work, where two people who are leaders (at least at the management level) don't do their other duties but focus just on the background of the problem," he explains. "They go to the worksite for measures, of which time is the main metric." This is one thing that distinguished lean from Six Sigma, he notes. "It specifies the main metrics as time, whereas Six Sigma's is defects," says Abelson.

Another key metric, he continues, is cycle time — the amount of time that is spent actually doing the process. "Most of the time, that is much less than the lead time," he notes. "If a lab result takes five days, the amount of staff time involved is probably 20 minutes, so the rest of time is probably wasted time."

In an RPIW, one site is chosen as a pilot. Using stopwatches, the leaders determine how long the process takes from the patient's point of view. "This is essential for any kind of lean effort," notes Abelson.

So, for example, when examining prescriptions, they looked at how many refills came in within a reasonable time, how they were processed, and how long the doctors, nurses and pharmacists spent on the process. "Then, in the fourth week, a team of stakeholders is assembled [in this case doctors, nurses, pharmacists, and a receptionist] and given one morning of training," says Abelson. "In the first half of the day, they are expected to make changes and come up with idea sheets." So, for example, if the problem is lost papers, the idea sheets would note ways of solving that problem. "Over the next two to three days, they make as many changes as possible, using lead time and cycle time as the main metrics," Abelson adds.

So, in terms of refills, the team noted that the hospital had some existing software for phone messaging. "They thought it would be a great way to communicate that a refill request had been submitted," Abelson recalls. "They did not want to have the physicians spending time on every single refill request, so they developed some protocols nurses could use that would enable them to refill about 75% to 80% of the requests with just an 'FYI' for the doctor."

So, instead of the physicians looking at 100% of all refill requests, they now look at perhaps 15% to 20%. "It not only eliminated a lot of work for the doctors but long waits for the patient," Abelson observes. ■

JCAHO to look closely at patient handoffs

Communication lapses will be key focus

An emergency department patient is brought in for an X-ray, but the nurse forgets to tell the radiologist about the patient's allergy to contrast dye. During a change of shift, a caregiver doesn't mention that the patient is at high risk for a fall injury. When a patient is transferred, the receiving facility isn't given a complete list of medications the patients is taking.

Whenever patients are "handed off" from one health care provider to another, it is a dangerous time, according to **Peter Angood**, MD, vice president and chief patient safety officer for the Joint Commission's International Center for Patient Safety.

"I think the important message out of this is that

the JCAHO has gathered a decade's worth of data related to sentinel event activity — and a common theme that's always at the top is the issue of communication," he explains. "And one of the most important areas is handoffs. It's a high-risk period, and there is a tendency to undercommunicate."

Clinicians are now being challenged to demonstrate that processes are in place to address all types of hand-off communication, with the JCAHO's new 2006 National Patient Safety Goal #2E. Organizations must implement a standardized approach to hand-off communications, including an opportunity to ask and respond to questions.

You must have processes in place to ensure that information is transferred from one caregiver to the next on the patient's condition, current problems that are active or potentially active, and the stability or potential instability of vital signs or physiologic status.

"What surveyors will be looking for is that institutions have implemented the structure and processes to effectively deal with managing handoffs," Angood says.

What they are looking for

Surveyors also will be looking for obvious lapses or processes that contribute to poor communication during handoffs, such as the use of tape recorders, illegible handwriting, use of nonstandardized forms, and the inability to contact an individual for follow-up questions.

"We are not being too prescriptive about all this, because there are a multitude of environments out there," says Angood. "Ideally, there should be good face-to-face communication. And if needed, there should be a way to contact people to clarify issues about patient care."

The problem with tape recorders is that there may be a tendency to provide minimal information if the staff person is eager to get off duty, says Angood. "They will occasionally miss information. And you've got the new person coming in trying to settle into their day, listening to the message while patients are arriving, which results in inattentive listening."

Inconsistent communication during patient handoffs has, at times, led to a patient's safety being placed at risk, says **Rita Stockman**, RN, MSA, director of hospital quality at William Beaumont Hospitals. The organization recently implemented a re-engineering process to address handoffs.

"The risk may be due to a gap in information, or perhaps the inability to rapidly locate the information in the medical record," says Stockman. "Variances in the reporting process have been demonstrated over time."

A "Hand Off Task Force" designed and implemented an improved process for transfer of inpatient information. The goal was to ensure that during a patient transport, each team member plays an active role in handing off the patient.

A "Transport Procedure Checklist" documents the transfer of the patient — and responsibility for their care — from one department and caregiver to another.

"Each caregiver involved in this handoff plays a distinct role in ensuring the clinical information is current, actively communicated, and that the patient is safe," says **Jayant Trewn**, PhD, the organization's research engineer.

The project was implemented from March 2004 to July 2005, with five teams, as follows:

- The "Continuity of Care" team designed the hand-off project.
- The "Data Elements" team determined the data elements that were to be included in the hand-off form.
- The "Performance Standard & Transfer of Information" team determined the performance evaluation standards and an information system to access data elements.
- The "Research and Publication" team developed and implemented the hand-off project evaluation methodology and assessed the success of the change.
- The "Education Subgroup" developed and implemented the hand-off training. The project was steered by a core group, with monthly review meetings held. A "Plan, Do, Check, Act" methodology was used, with the following cycle of activities: Evaluation of current hand-off process, redesign of hand-off process, testing of new processes using direct observation and user feedback, redesign of the process and form, implementation of revised form and reevaluation of change, and ongoing monitoring of the hand-off process.

The evaluation and feedback information was used by the task force to revise the form and improve the hand-off process. During the pilot, emergency department (ED) staff identified the need to include a separate form for their admitted patients, since there were specific data elements that needed to be included.

The hand-off process is being monitored on a monthly basis by the task force, using direct observations on a sample of handoffs as they occur on units. ■

Discharge Planning Advisor®

– the update for improving continuity of care

- **Accelerated discharge**
- **Staff cooperation**
- **Placement strategies**
- **Reimbursement**
- **Legal issues**
- **Case management**

System achieves 'right patient, right level of care'

Training nurses to ask questions was key

An increasing number of one-day stays and patients who failed to meet admission criteria formed the impetus for a throughput initiative that is reducing inappropriate admissions at Sutter Health in Sacramento, CA, says **Barbara Leach**, RN, director of case management for Sacramento Yolo Sutter Health.

"My personal driver was getting patients into the right status of admission," she adds. "There is so much confusion, so much [area] that is gray, when an outpatient needs to remain for a longer period than normal because of unforeseen complications."

The Center for Medicare & Medicaid Services (CMS), Leach notes, sets a target percentage for one-day hospital stays by Medicare patients. The rationale, she explains, is that if a patient is only in the hospital for one day, the question arises as to whether the person might more appropriately have been given observation status, for example, or referred to a skilled nursing facility.

That issue, combined with the push to meet InterQual criteria — a group of measurable clinical indicators and diagnostic and therapeutic services that reflect a patient's need for hospitalization — set the stage for the effort to place "the right patient in the right hospital at the right level of care, Leach says.

The first pilot project took place last June at Sutter General Hospital, she says, with a team composed of a case manager, a patient placement nurse already charged with assigning beds, and bed placement clerical staff who keep track of admission data and verify insurance eligibility.

"We live in an area where people change [insurance] carriers all the time, so one issue is determining whether a patient should even be admitted to this hospital," Leach notes. "We were often not finding out until a day or two later that someone was capitated to another hospital. The other hospital calls and says, 'Thanks for providing open-heart surgery to our patient.' It doesn't take too many of those cases to feel like you're hitting bumps in the road."

Even if there still is the opportunity to transfer after a patient in another managed care plan is inappropriately admitted, she points out, "there is the disruption to the patient who has to move, and the expense to our hospital. We [incur the cost] of the most expensive day, and then we have to move the person to another facility."

To hospital administrators, Leach adds, she emphasized the initiative's focus on controlling access so that only appropriate patients are admitted. To physicians, on the other hand, she stressed that it would facilitate the admission of their patients.

While some hospitals have a similar process in place for planned admissions, she notes, the Sutter project was designed around unscheduled admissions, which are "our Achilles heel."

"We had all these people managing information," Leach says. "They verified that [patients] had appropriate insurance and they validated with information from physicians that patients met InterQual criteria for level of care — whether telemetry, intensive care unit (ICU), observation or inpatient."

Once the level of care was established, the patient placement nurse was asked if a bed of that type was available, she says.

In the past, Leach adds, physicians would call and say they needed a bed at a certain level of care, and staff would respond that it was available or not. "We never knew [at that point] if the patient met criteria. Or, the [patient placement

nurse] might say, 'I don't have an ICU bed, but can you take a telemetry one?' It might turn out that's what the patient needed anyway."

The project also has "allowed us to dialogue" with physicians in the emergency department (ED) — where there is a case manager — when patients don't meet InterQual criteria, she says.

"[The case manager] can say, 'The patient doesn't meet inpatient criteria, but may need placement in an SNF [skilled nursing facility], and I can help you with that,'" Leach continues. "Or she can say, 'I need more information to qualify this patient for emergent admission. Please document the tests and procedures you are planning for this patient.'"

That means, she adds, that when physicians admit patients and say they'll check on them later, the response now is, "That's not enough — we need a plan of care in order to move [the patient] along in the process."

Recognizing the potential for conflict that questioning physicians about their orders can cause, she notes, staff choose their words carefully.

Instead of saying, "The patient doesn't meet criteria," and having the physician respond, "I don't care — admit him anyway," Leach says, "We might call and say, 'We need to better understand the treatment plan so we can put the patient in the right place.'"

In the past, she explains, physicians would simply write the orders and the patient would be taken to the nursing unit. "We would have that dialogue [with the physician] 24 hours after admission when the case manager was doing the utilization review and would say, 'Why is this person here?'"

Inappropriate admissions avoided

As a result of the Sutter General pilot, Leach says, staff were able to identify a number of ED patients that otherwise would have been inappropriately admitted to the hospital and refer them to outpatient treatment, place them in SNFs, or have them transferred to the facility designated in their managed care plan.

For all 51 patients admitted during the pilot — which was confined to the hours between 8 a.m. and 5 p.m. — staff were able to document that they met the criteria for admission," she says. "That's not a huge number. We did this during a time when we were not getting slammed so we could work our process and have the necessary resources available."

By communicating with physicians, staff avoided admitting between seven and 12 people as inpatients, instead directing them to observation status or another type of care, Leach notes. "For example, physicians often will admit patients to the hospital for infusion, for hydration, but we have a clinic where that is done, so we can help set that up."

In the months since the pilot, the proactive communication with physicians has continued to work beautifully, she notes, adding that since the project began, with "every patient about whom [nurses] have dialogued with the physician regarding either level of care or criteria, the issue has been resolved prior to admit."

"The key has been to adequately train the patient placement nurses with questions to ask and alternatives to offer the physicians so they can be sure the patients are getting the treatment they need," Leach says. While Sutter Health has had the patient placement nurse function for some time, she says, formerly the job "was only to figure out what bed to put the patients in."

Apart from causing a financial loss to the hospital, Leach points out, she believes that inappropriate admissions are a quality of care issue. "The risks of being in the hospital — falls, medication errors, bed sores, infection — are all well documented. Those are all things that we are able to prevent if a person is not admitted unnecessarily to the hospital."

A pilot project done at the health system's other hospital, Sutter Memorial, was a much bigger challenge, she says, because the majority of unscheduled admissions come through services other than the ED. That hospital, Leach explains, is located in a residential area and specializes in pediatrics, obstetrics, and cardiology. It also is a larger facility than Sutter General. Together, she notes, the two acute care facilities have well over 600 beds.

"Cardiology patients often come through emergent admits from other hospitals or scheduled admits from interventional procedures, such as heart catheterization or diagnostic imaging," she says. "We are dealing with specialists and with patients who are having procedures, not coming to the ED with a cold."

Because the patients being admitted may already be outpatients or may be coming from another facility, Leach adds, it is easier for them to "slip through the cracks." During the Memorial pilot, she says, only nine people were admitted through the ED.

Although data from that pilot haven't been analyzed, Leach says, "we know anecdotally that we were very effective in the ED and that — even with the lesser number of admissions — probably impacted the same number of patients who were at the wrong hospital or needed to be hooked up with other services."

Hospital administrators initially were concerned that the steps involved in ensuring proper placement would delay patient throughput, she notes. "We provide tertiary care for multiple areas, so we have a specialty services network from all over California. We don't want to lose that business by putting up barriers to admission."

Those fears proved to be unfounded, Leach says, noting that in both studies, the length of time between a patient presenting at the ED or outpatient department and being admitted to the hospital did not increase.

In fact, the time may have been shortened, she adds, "but we don't have enough data to show that yet."

While the project's patient placement nurse is currently working 10 hours a day, the goal is to have the kind of patient coordination done in the pilots in place around the clock, Leach says. "We'll probably be making decisions on [hiring] that person or people based on some volume studies."

(Editor's note: ***Barbara Leach*** *can be reached at LeachB@sutterhealth.org.)* ■

CHF project aims to bridge gap between providers

Goal is better outcomes, fewer readmissions

Drawing on 20 years of quality improvement experience, MPRO, Michigan's Health Care Quality Improvement Organization, is bringing together hospitals, home health agencies, and physician practices to come up with solutions to communications barriers between providers, with the ultimate goal of improving the outcomes for the state's cardiovascular disease patients.

"In the state of Michigan, no one has brought different groups from across health care setting together at one table. This pilot project is the first time that hospitals, home health agencies, and physician offices come together to work together for better patient outcomes," says **Linda Charles**,

CE *questions*

1. How often does Sekander A. Ursani, CPE, MD, medical director Southern Ocean County Hospital make rounds with the case management staff?
A. Daily on each unit and weekly for managed care patients
B. Every day for all patients in the hospital
C. Every day for managed care patients
D. When the case manager request it

2. A collaboration between the case managers and their physician advisor at Mercy Medical Center in Canton Ohio resulted in a drop in Medicare length of stay from 6.83 days in 1998 to how many days in 2004?
A. 5.83 C. 5.07
B. 6.30 D. 6.07

3. Condition Code 44 allows hospitals to convert an inpatient admission to an outpatient admission if the hospital's utilization review committee determines the patients doesn't meet inpatient criteria under what conditions?
A. The patient is still in the hospital
B. The hospital has not submitted a claim to Medicare for the hospital stay
C. The attending physician concurs and documents concurrence in the patient record
D. All of the above

4. At what intervals does Medical City Dallas Hospital's case management department hold a medical necessity meeting and discuss, among other things, changes in insurance requirements?
A. Every day
B. Every two weeks
C. Once a week
D. Once a month

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

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. ■

RN, BS, project coordinator for MPRO's hospital quality improvement team.

MPRO has been awarded a contract with the Michigan Department of Community Health for the pilot project "Cardiovascular Health Project." The goal is to reduce the number of hospital readmissions for patients with cardiovascular disease, especially congestive heart failure (CHF) by reinforcing education and self-management before and after hospitalization.

The project aims to improve the consistency of documentation, patient assessment, and reporting of clinical findings and to close the gap between the hospital, home health agencies, and physician offices.

"The goal of the heart failure collaborative across settings is not just to decrease readmissions. Other goals are to reinforce heart failure patient education and self-management prior to and after hospitalization and to help the patients gain more control over the disease process," says **Teri Aldini**, RN, MS, project manager for the home health and hospital team.

Heart failure is the leading diagnosis for Medicare patients in the state of Michigan and is among the leading diagnoses for hospital readmissions.

The 325,000 patients discharged with a diagnosis of heart failure last year incurred approximately $226 million in hospital costs. About 25% are discharged from Michigan hospitals with a home health referral.

"When we worked on cardiovascular quality improvement projects in the past, our team had observed the disconnect between the hospital, the home health agency, and the physician office. We wanted to create a collaboration between the hospitals and home health offices, realizing that the physician's office is an integral part of post-acute care," Charles says.

The disconnect appears to occur when patient care is managed by a cardiologist while the patient is hospitalized and following the patient's discharge home, care is then resumed by the primary care physician.

Typically, the cardiologist will discharge the patients to home with home health and the patient receives post-discharge instructions from the hospital but it takes a while for the discharge summary to reach the physician's office. If the patient has a question or an acute event or the home health agency calls for further orders, the physician does not have the information he or she needs to prescribe follow-up care.

"Even if a primary care physician assumes care in the hospital and writes a home health referral, he has the knowledge of what happened in the hospital but the office staff may not, and they are the ones who typically triage the patients," Charles says.

The project aims to integrate care across all settings to improve patient outcomes by bringing together hospitals, home health agencies, and representatives from physician offices for two intensive learning sessions during which the providers share ideas about improving communication.

"We serve as facilitators at these sessions, bringing different stakeholders together and giving them the opportunity to identify where the problems are and work on solutions to overcoming barriers. It's the responsibility of the providers to adapt the lessons they learned when we were together and change the process of care in their individual settings," Charles adds.

MPRO holds a monthly conference call in which participants report on what they have implemented.

Participants include hospital and home health quality improvement staff, home health administrators, hospital discharge planners and offices managers, and sometimes nurses from physician practices. The pilot project with the Michigan Department of Community Health involves two hospitals, three local home health agencies, and four physician practices.

The organization has led a number of other cardiovascular quality improvement initiatives, including the Michigan Heart Failure Discharge Documentation program, developed with Blue Cross and Blue Shield (BCBS) of Michigan and the Michigan chapter of the American College of Cardiology.

The aim of the project is to ensure that admission and discharge orders meet the Core Measures for quality established by the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission on Accreditation of Healthcare Organizations.

The team brought together 39 participating Michigan hospitals for intensive learning sessions and sharing ideas to make sure the quality initiatives are being met.

"The goal of the program was not just to increase the rate of discharge instructions documentation but to increase patient knowledge and to give the patients more tools to help them control their disease process and adapt their lifestyles," Aldini says.

The hospitals received a template document designed to improve the documentation for the six core measures for heart failure and were encouraged to use it or adapt it.

MPRO followed up with conference calls in which hospitals reported their use of the tools provided.

As a result of the project, hospitals in Michigan have begun sharing tools that help them address the Core Measures and other quality initiatives, Aldini says. ■

Contracts

(Continued from page 6)

case management when a new contract comes up for renewal. Case managers have the information and understanding of the impact of contract language on their job, and they are in a position to know if what the insurer is demanding is something they can or can't do," Cunningham says.

At the very least, you should make sure that the people who are negotiating the contracts between managed care companies and your hospital understand the impact of contract language on the case management processes.

The best-case scenario is for a representative from case management to be involved before the contract is negotiated to make sure that the contract requirements can be followed.

"Case managers should be at the table when the contracts are negotiated or meet with the people who are handling the managed care contracting to assure they understand what provisions case management needs in the contract," Cunningham says.

For instance, if your hospital uses an automated call system to provide clinical information, make sure the insurance company will accept information in that manner.

The contract should specify which criteria the payer uses so the case managers will understand how the payer will determine medical necessity.

"Rather than having the insurance company write all the requirements, we need to have a say as to what goes into the contract," she explains.

All case managers in the hospital should be aware of what they need to document and how their work processes should change whenever there is a change in an insurance contract.

At Medical City Dallas Hospital, the case management department has a biweekly medical necessity meeting for all the nurse case managers. The focus of the meeting is payer medical necessity issues, including new provisions in managed care contracts.

At the medical necessity meetings, the staff walk through the whole process that is being required by the insurance company. If Cunningham has concerns about the contract operations with the payer, she calls the division managed care vice president and asks for a conference call with the insurance company.

For instance, insurers may change from one criteria set to another during the course of the contract. They may change their focus for post-acute care and prefer discharging patients to skilled nursing facilities instead of long-term acute care facilities or rehabilitation facilities.

"We look at the things that are going to affect case management. There are many contract terms that affect our case management processes," says Cunningham.

In the past, insurance companies imposed penalties when the hospital didn't notify them of an admission, regardless of whether the admission was inpatient, outpatient, or observation. Now, more insurance companies want patients in observation but don't require notification for observation status.

However, should the patient be moved to inpatient status, the insurance company must be notified, she notes.

For instance, insurance companies require notification when the hospital stay of new mothers or newborns is extended. If an insurer requires clinical information on patients when they are admitted and they don't get it, they may deny those days, Cunningham points out.

"Case managers should be aware of this so they can act because the hospital will incur penalties if they don't call in the clinical information to the

COMING IN FUTURE MONTHS

- Why it's important to understand your patients' health care literacy
- How case managers and hospitalists can work as a team
- One hospital's success in cutting down on 'frequent fliers'
- Proving the value of your case management program

insurance company in a timely manner," she says.

Managed care staff at the hospital don't always realize how involved case managers are in helping avoid denials.

If they don't let the case management department know when there are changes in a contract, the case managers could be missing something they're supposed to do and never know it, says Cunningham.

For instance, most contracts are negotiated to last one to five years, but insurance companies often add an addendum or make operational changes during the course of the contract.

If the hospital contracting staff don't pass the information on to the case management department, the hospital could be at risk for claims denials.

In a move that has a major impact on how case management works, Texas Health Network just added a requirement that the insurer must know the DRG the hospital will bill before the bill drops. If the DRG that is billed is different from the DRG that is pre-certified, the insurer will pay only for the pre-certified DRG. This poses problems if the patient is admitted and pre-certified with a working DRG and his or condition turns out to be much more serious, unless the insurer is notified of the new DRG.

For instance, a patient comes in with abdominal pain and is given a precertified DRG of abdominal pain. Should the patient have surgery and end up in the intensive care unit with cancer, if there is no notification of the change in the DRG, the hospital will be paid only for the abdominal pain DRG.

"We had a conference call with them to understand what it all means because it is requiring us to change processes," she says.

Hospitals need to establish a process that allows regular conversations between the hospital case management staff and the payer representative and medical management staff, Cunningham says.

"I have a great working relationship, and the flow of information back and forth is very open. They will call me or, if I have problems, I will call them," she says.

Cunningham has a computerized file with all of the contract terms for each insurer that contracts with the hospital.

"Case managers need access to those contract terms. They need to know where stop-loss starts and how we are paid. They must understand the appeals process and understand any carve-outs," she says.

In addition, the case management staff should be aware of how their hospital is paid in specialty areas, such as the neonatal intensive care unit and medical-surgical unit and how they are different.

"On my computer, I have all that information for every hospital in my division for all our contracts," Cunningham says.

If case management directors don't already have detailed information on all of the contracts their hospital has with insurance companies, they should ask the person responsible for managed care contracts for the information.

"It's essential to have all that information in order to do your job effectively," she says. ■

CE objectives

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■