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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Discharge planning and the dilemma of dealing with homeless patients

What do you do when they want to live on the street?

The camera got it all on tape: A taxi disappearing from view and then 63-year-old Carol Ann Reyes, clad in a hospital gown and slippers, wandering San Pedro Street in the Skid Row area of Los Angeles until someone escorted her into the nearby Union Rescue Mission building.

Reyes, who had been hospitalized for three days at Kaiser Permanente's Bellflower facility, later told reporters she could not remember what happened when she left the hospital or how she got to the place where she was found.

According to the Associated Press, several hospitals have acknowledged that they send patients who have nowhere else to go to that area because the services and shelters are there.

Jim Lott, executive vice president of the Hospital Association of Southern California, says the problem has been blown out of proportion.

"More homeless people are dropped off in downtown LA by law enforcement officers than by hospitals. Homeless patients need a lot of outpatient care, but not that many are hospitalized," he says.

There are about 80,000 homeless people in 88 different cities in Los Angeles County, but the vast majority of the services available for the homeless are in the city, Lott says. "When the homeless are discharged from the hospital or let out of jail, they are brought into the city because that's where they can get help," he says.

The Reyes incident made national news, but left unexplored in most press accounts was the larger issue of how hospitals are supposed to deal with patients who have no fixed address, no income, and no family or social support.

"The number of homeless is increasing in many communities, and it's not being dealt with effectively. People with mental illness, alcohol, and drug problems have long been among the homeless, but in recent years,

more families are hitting the street as a result of job loss," says **Kathy Hearne**, MSSW, coordinator of respite care providers for the National Healthcare for the Homeless Council, with headquarters in Nashville, TN.

And no matter how hard case managers and social workers try, there are some homeless people who simply don't want to go to a shelter.

"Some individuals who are homeless choose to be homeless, and they remain homeless when they leave here, no matter what we do," says **Greg Jensen**, ACSW, LISW, director of social services for the University of Iowa Hospitals and Clinics in Iowa City, IA.

"The homeless come to the hospital only as a last resort. They don't come looking for anything more than having their immediate needs taken care of," says **Winnie Coburn**, RN, CPHQ, director of care management for Carondelet Health Network in Tucson, AZ.

Sometimes, their friends or colleagues on the street bring homeless patients to the hospital, or they pass out and an ambulance is called, Coburn adds.

"We clean them up, get them fed and bathed and give them the medication they need and they're ready to go back on the street," she says.

When a patient is identified as being homeless at the point of admission, that should trigger a set of responses, Lott says.

"At a minimum, the staff should obtain clothing and consider giving the patient a cash allowance to get to a low-cost hotel. We do that much for prisoners. Discharging them in hospital gowns is not a good visual, nor is it humane," he says.

Informed consent

Hospitals can run into trouble if they transfer homeless patients to places they don't want to go, Lott points out. "The Los Angeles City Attorney has told us that we have vulnerability if we send patients someplace against their will," he says.

The hospital association has advised hospitals to get an informed consent from patients indicating that they agree to their discharge destination, including that they want to go back on the street.

"We do recommend that hospitals try to connect homeless patients with social services agencies before they send them anywhere. And for their protection, they need expressed written consent that that patient wants to go where the hospital is sending him," Lott says.

Hospitals are in a Catch-22 situation when patients are medically stable enough to be transferred to a lower level of care, he points out.

"Hospitals cannot discharge a patient to another medical facility unless that facility agrees to take them. It puts the hospitals in a tough bind because they shouldn't discharge patients who require follow-up care unless they know it's available," Lott says.

"We struggle like everyone else struggles to find a discharge destination for patients who are homeless. We work with their friends, with local

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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**.

churches, and community agencies to find a safe discharge destination," Jensen says.

At the University of Iowa Hospitals and Clinics, staff can tap into the hospital's expedited discharge funds to pay the daily rate to a shelter to house homeless patients while they recover from an illness or injury. **(For more information on their programs for indigent patients, see related article, this page.)**

"So we don't burden the local resources, we can pay for two to three weeks in a shelter while the patient receives IV antibiotics or recovers more fully," Jensen says.

"Each case is unique. Minimally, we work with a homeless shelter and see if we can reimburse them for some of their services. If a patient needs IV antibiotics, we provide them," he adds.

Physicians make the determination of whether a patient can be safely discharged.

"Some do stay here because they literally have no place to go. They may stay two to three weeks more than is medically necessary while they are convalescing. You just can't take someone who can't get out of bed and put them on the street," Jensen says.

Seton Healthcare System sometimes pays for homeless patients to go to an assisted living center, or a group home if they aren't ambulatory or otherwise need to recover. On rare occasions, the health care system has paid for a hotel room for patients who had a short recovery period.

"It makes good financial sense. It gets patients to the proper level of care, the nurses no longer have to care for patients who don't need to be here, and it opens up the bed for patients who have funding," says **Pat Beal**, LCSW, outpatient case management supervisor and Northwest Operations Manager for the Austin, TX, health care network.

A solution in some communities has been to establish a respite shelter where patients can receive around-the-clock care supervised by doctors and nurses, Hearne says.

Most shelters don't stay open during the day. People have to leave the shelter in the morning and come back at night. Respite shelters are a combination of a shelter and a health care clinic, Hearne says. Many have grown out of health care for the homeless programs in the community.

Eligible patients may include someone who has a staph infection and needs IV antibiotics or someone who is terminally ill, she says.

"You can't keep someone in the hospital when they have just a few months to live, and you can't put them out on the street. Respite programs offer an option," Hearne says.

One of the goals of the National Healthcare for the Homeless Council's annual meeting in Portland, OR, June 7-10 is to forge more relationships between hospitals and community agencies working with the homeless, she reports.

"There are no easy answers for any of this. The bottom line is that case managers have to be very creative and to engage every community resource that is available. Ask everybody for help and keep asking. All they can do is say no," Coburn says. ■

Network targets barriers for unfunded patients

Strategies include paying for a lower level of care

When patients at hospitals in Seton Healthcare Network are ready for discharge and don't have funding for post-discharge services, the hospital may pay nursing homes to provide care until their Medicaid eligibility is determined or place patients in assisted living facilities temporarily until they fully recover.

"It simply does not make sense to have the bed filled with someone who does not meet acute care criteria and who can't pay the bill. Paying for the care patients need after discharge is a good move because the patient is no longer in an acute care bed when they don't need to be there, and the hospital can fill that bed with a funded patient. It allows us to increase revenue while saving costs," says **Pat Beal**, LCSW, case operations manager for Seton Northwest Hospital and outpatient case manager.

Austin, TX, where Seton has headquarters, has a huge homeless population. Since it's in a border state, the city also has a high number of undocumented workers, says **James Brown**, MD, vice president and medical director for Seton Health Plan and case management.

The health system takes a proactive approach to planning the discharge destination for homeless and unfunded patients and ensuring that they are not readmitted.

Each weekday, Brown meets with the case management and social work staff for complex discharge rounds, during which they discuss patients who have been in the hospital for at least five to 10 days. The number may be considerable. For instance, one day recently, there were 44

patients in Brackenridge Hospital whose stay exceeded 10 days.

The team identifies barriers to discharge and comes up with ways to address the issues, particularly related to unfunded and homeless patients. "We make sure we have a disposition plan and start planning a discharge destination," Beal explains.

A few years ago, Brackenridge Hospital had a lot of patients with Medicaid or SSI disability coverage pending who had extended stays because they were too sick to be discharged to home but nursing homes wouldn't take them until their eligibility for Medicaid was assured, a process that can take as long as 10 months, she says.

The hospital has arranged to pay the Medicaid TILE rate for nursing home care until Medicaid approval comes through, if a cost-benefit analysis shows that the hospital will save money by doing so. In that case, the nursing home bills the hospital monthly for what Medicaid would have paid. When the patient is approved for Medicaid, the nursing home will get a check from the Centers for Medicare & Medicaid Services for the back payments and reimburse the hospital.

"It's a great thing. It gets the patient to the proper level of care and opens up beds for patients who do need nursing care. We haven't recouped 100% of the money we've paid to the nursing homes, but we have been correct in determining that the patient will eventually be approved for Medicaid," she says.

Before the hospital agrees to pay for a patient's nursing home care, Beal does a cost-benefit analysis of moving the patient.

She determines the average cost of the patient's last six days of care, using 30% of charges as the cost basis. Beal then compares that to the cost of transporting the patient, providing medication, and the average daily rate that Medicaid will pay to a nursing home.

"The hospital's chief operating officer signs off on the transfer. It's always turned out to be a tremendous cost savings for us," she says.

Beal also compares what the hospital will be paying to the nursing home with what the hospital could recoup by putting a funded patient in the bed.

"The program has been extremely successful. It's helped us to get the patients to the right level of care and to a place where they are not susceptible to hospital-borne illnesses. The hospital has avoided being on diversion, and we can increase our revenue if we have a funded patient in that bed," she reports.

The hospital is willing to pay for the nursing home care only if there is a likelihood it will be reimbursed, she adds.

Paying for home care

The hospital has a partnership with an acute rehabilitation facility which offers two acute rehab charity beds each day, with the stipulation that the patients need to be in rehab only two weeks. In addition, the hospital pays for whatever equipment unfunded patients may need in order to go home. For instance, the hospital has rented wound vacs or provided special mattresses so patients can be discharged.

Each hospital in the Seton Healthcare System pays for the cost of its patients' home care if they lack resources.

"Paying for home care makes good financial sense because the patient is no longer in an acute care bed when they don't need to be there," Beal says.

When patients are too sick to be on the street but not sick enough for skilled nursing care, the case managers sometimes can find them a place at a community facility to continue their recovery.

The Salvation Army sick bay will accept some patients for a limited amount of time. The City of Austin operates The Arch, with a six-bed infirmary where homeless patients can get care.

"On very rare occasions, we have discharged a patient to a hotel and arranged from them to have meals from a soup kitchen. This is only in cases where the patient needed bed rest for a short time, such as recovering from a sprained or broken limb and there is no other placement option available," she says.

When patients need long-term care and don't qualify for disability because they are going to heal, the hospital contracts with assisted living facilities or group homes where they can get their meals and receive home health services if necessary.

These may be patients with two broken legs or those who need IV antibiotics. "The ones we can't do anything about are IV drug abusers who need IV antibiotics. We can't send them out with an open line so they're here for the duration of the IV antibiotic therapy," Beal says.

Seton Healthcare funds and operates three primary care clinics for indigent patients in parts of the city where there is a need, Brown says.

The clinics help keep nonemergent patients out of the hospital and provide continuity of care in

management of chronic conditions such as high blood pressure and diabetes.

"When patients come to the emergency department for primary care, they are treated by whoever is available. When they go to our clinics, they see the same provider over and over. We hope that we can manage the care for patients in our clinics and help them ward off costly complications of their chronic diseases," Brown says.

When indigent patients present at the hospital, they go through a screening process to determine what kind of aid they might qualify for, such as Medicaid or one of the federally and county-funded programs in Austin that provide care for unfunded patients.

If they don't qualify for any other care, when they are discharged, they are referred to a Seton clinic to use as their medical home. They pay a nominal fee for their care, based on their income and other resources.

To accommodate the burgeoning numbers of indigent patients, Seton Healthcare has expanded its clinic hours to give patients a chance to come into a clinic in the evening hours, instead of using the emergency department for primary care.

The clinics are funded through the health care system's charity care funds and donations from the community.

In addition, the hospital has arranged for specialty providers in the city to provide free care for indigent patients. The hospital provides hospital and ancillary services for these patients.

Approximately 5,000 of the uninsured patients using the Seton Clinics for primary care have been enrolled in a health plan "look-alike," according to Brown. They pay a nominal amount for office visits and prescriptions, based on a sliding scale according to income.

"We manage the patients who use our clinics as if they have health insurance. They get a card that they present for treatment. Our goal is to manage their care, to prevent readmissions, and to try to educate them not to use the emergency department as their only source of care," he explains.

*(Editor's note: For more information, contact **Pat Beal**, LCSW, at e-mail: pbeal@seton.org.)* ■

Approach increases reimbursement, cuts LOS

ED social workers help avoid social admissions

A multipronged approach has helped the University of Iowa Hospitals and Clinics find funding for indigent patients, cut the length of stay for patients who are medically able to be discharged, and reduced the number of nonemergent visits to the emergency department (ED).

Many of the homeless and indigent patients in Iowa City are treated at the University of Iowa Hospitals and Clinics. Many of those patients present with barriers to discharge and complicated social needs, says **Greg Jensen**, ACSW, LISW, director of social services.

Social workers assigned to the ED help avoid admissions of patients who do not meet acute care requirements and provide case management services for patients who use the ED for primary care. Other dedicated social staff help indigent patients fill out applications for Medicaid, disability, and medication assistance.

When patients are ready for discharge but remain in the hospital because they don't have a way to pay for the equipment, supplies, or medication they may need, discharge planning staff can tap into the hospital's expedited discharge fund, which can be used to get the patient what he or she needs to be discharged.

"If a patient is medically ready to leave, the social workers can start the application process to use the fund to transport patients to home, provide antibiotics or equipment. This has been helpful in shortening our length of stay," Jensen says.

A multidisciplinary team conducts weekly review rounds for any patient who has had a length of stay of more than four days. The unit social workers provide a status report. A physician is available for consultation and to talk with the treating physician if there are medical issues. In a typical week, 250-280 patients are reviewed.

"We look at whether there is something we might do from an administrative, social, or medical perspective to assist with getting them discharged," Jensen says.

"This process raises the attention of the treating physician and the social workers on the unit to see if these patients can be moved through the continuum more efficiently and timely," he says.

Social workers staff the ED from 10:30 a.m. to 11 p.m., seven days a week, working with the ED staff to find a place for patients who don't require acute care. In just six months, the social workers averted admissions of 46 patients who would

have been admitted for social reasons.

Some of those patients were elderly people whose family was having trouble caring from them at home.

"The social worker conducts crisis intervention with the family. They look at getting respite care or home health arranged for the families so they have support," Jensen says.

University of Iowa Hospital is the only teaching hospital in the state and often receives patients from other facilities and nursing homes. Sometimes these patients don't meet acute care admissions criteria, but by the time the ED staff determine it, the ambulance has driven away.

In those cases, the social worker calls the referring facility and uses the expedited discharge fund to pay for an ambulance to take the patient back.

"Before we had a social worker on-site, the emergency department would admit patients and let somebody know about it the next day," he says.

By providing case management services for patients who use the ED as a primary care provider, the ED social work staff have been able to reduce visits by nonemergent patients by 59%.

"Coming to the emergency department for treatment is not the most efficient or coordinated way to get care. The patients are not likely to have the same doctor every time, and the clinicians respond only to what brought them in that night," Jensen says.

When the program began, the emergency department staff compiled a list of patients who came in frequently and who could better be cared for by a primary care physician, Jensen says.

When one of the patients on that list comes into the ED, a social worker meets with them, assesses their needs, and finds out why they are using the emergency department frequently. They develop a plan to help the patient connect with community-based resources, such as substance abuse programs, and to find a primary care physician.

"Many of these patients are near-indigent. Some are drug seeking or have behavioral of psychiatric issues at play. Others are victims of domestic violence. They typically have complex psychosocial needs, as well as medical needs. We give attention to both needs," Jensen says.

The hospital has developed a healthcare benefits assistance program to help patients who are admitted without a payer sign up for Medicaid and disability benefits.

In fiscal year 2005, the staff took 1,918 applications for Medicaid. Of those, 1,348 or 70% were approved, resulting in more than $19 million to the institution. Of the 491 applications for disability payments, 75% were approved.

"These patients went from having no payer to having a payer," Jensen reports.

Staff are trained to take Medicaid and disability applications at the bedside.

"The staff follows patients after discharge because it could take three to six months for the application to be approved. They assist with appeals if the application is denied," Jensen says.

In addition, three staff members coordinate a medication assistance program to identify whether patients are eligible for any pharmaceutical programs for the indigent.

"This has been helpful in terms of getting patients access to the medications they need to prevent a readmission. Lack of medication is a huge problem. If a patient can't get insulin or an IV antibiotic, we can't discharge them without their medication," Jensen says.

(Editor's note: For more information, contact: ***Greg Jensen****, ACSW, LISW, e-mail: gregory-jensen@uiowa.edu.)* ■

Hospital funds, donations provide needed care

CMs take creative approach to finding resources

When indigent patients are ready for discharge but have post-acute needs, the staff at Carondelet Health Network in Tucson, AZ, sometimes dip into their own pockets to provide food, clothing, transportation, or medication to give patients the best chance for recovery after ischarge.

"When there's a real need and no other funds are available, the social workers and case managers will take up a collection among their colleagues to help the patient. Everybody dips into their own pockets to see that we do our best for these patients," says **Winnie Coburn**, RN, CPHQ, director of care management.

The social workers use their creativity to access community resources for patients who have no discharge destination. "We will not turn anybody out on the street unless we feel like they have a fighting chance," she says.

The staff get clothing for the homeless patients

(Continued on page 91)

CRITICAL PATH NETWORK™

Case managers help mentally ill avoid hospitalization, remain in the community

Program targets both adults and children

An intensive case management program at Community Hospital in Chester, PA, helps children and adults with serious mental illnesses manage their conditions, avoid hospitalizations, and stay in the community.

Community Hospital is a division of Crozer-Chester Medical Center, a 422-bed tertiary care hospital about five minutes away in Upland. Both hospitals are part of the Crozer-Keystone Health System.

The program, currently funded by the Commonwealth of Pennsylvania, was started in 1987, after a woman with a serious mental illness shot and killed six people at a shopping mall. The woman had made multiple visits to several psychiatric agencies but never stayed in treatment.

"That highlighted the fact that there are a lot of seriously mentally ill people in Delaware County who were not maintaining regular contact with a treatment program. The shooting was the impetus for outpatient mental health case management for adults. The children's program is an outgrowth of what happened with the adult program," says **Colleen Healy**, MA, MBA, director of child and family services for Crozer-Chester Medical Center.

The care of people in the program is coordinated by case managers who have a minimum of a bachelor's degree in the social services field. The case managers who work with the most seriously ill patients who need frequent contact are called intensive case managers (ICMs). Those who work with patients who are slightly less at risk and need fewer interventions are called resource coordinators (RCs).

The hospital is moving toward a blended model of case management, adapting the level of care to the patient's level of function to maintain continuity of care as the patients improve and need fewer interventions, reports **Terri Venello**, RN, director of adult and geriatric services at Crozer Chester Medical Center.

The hospital offers a full array of psychiatric and substance abuse treatment programs for all ages, from childhood to geriatric patients. A large percentage of the adults and children eligible for the ICM program are identified when they come in for a general psychiatric intake. The rest are referred by other providers, schools, inpatient hospitals, residential settings such as group homes, and other support services in the community.

Initially, the program was a maintenance program, aimed at keeping patients in the community. Recently the case managers have taken a more proactive approach to help patients recover from psychological illnesses. Recovery principles are being used to assist clients in developing plans to guide this process.

The intensive case management program is a 24-hour-a-day program. On weekends, one case manager is on call to assist people by meeting them in the crisis department if they need to be evaluated.

Almost all the adult clients in the case management program have diagnoses of serious mental illnesses, such as schizophrenia, major mood disorders, or depression. Some are substance abusers. Many have co-occurring disorders with substance abuse and mental health issues. A small subset has just come out of the prison system.

"With children, we're not dealing so much with chronic and serious mental illnesses. For many children, what we are trying to do is reduce their chance of being placed out of the home if they have a behavioral health issue," Healy says.

Children who qualify for the program are involved in a multiple child-serving systems, including mental health, special education, child welfare services, juvenile justice, drug and alcohol treatment, or mental retardation services. If a child is in two or three child-serving systems, he or she is evaluated for the program.

Eligible adults have had lengthy hospitalizations for mental illness, multiple face-to-face encounters with emergency service personnel, spent three or more years in a community mental health program, or have demonstrated an inability to comply with a medication regimen.

Caseloads

Intensive case managers carry a caseload of 18 children or 18-24 adults. Resource coordinators have a caseload of 22 children or 30-50 adults.

When a case manager gets a referral for a child in the program, he or she calls the family or the individual and arranges for a home visit within two weeks after the case is opened. He or she conducts a strengths-and-needs assessment of the child and the family and develops a service plan.

"The case manager and family work on what their goals are involving school, mental health treatment, and child welfare when needed. The plan gives us structure and focus," Healy says.

Many adult clients have been ill for so long that they have little family support or they don't want their families involved. In these cases, the case manager assists the client in developing a support network. All clients are assessed and participate in the development of a service plan that sets the framework for working with the patient.

Clients in the program fill out a self-assessment scale every six months, indicating areas where they feel they have improved and those where they still need help. The case managers use them to make any modifications to the service plan.

The ICMs and RCs are expected to spend 75% of their time in the community, going to homes, schools, courts, welfare offices, and anywhere else they can find their clients.

They make regular home visits to all clients and school visits with children in the program. If a child has a court appearance, whether it's for juvenile justice or child welfare, the case manager accompanies him or her and usually provides the transportation.

The case managers often accompany clients to clinic visits or to access community resources.

"The case managers pick them up and take them to appointments and do whatever it takes to help patients develop a more normal lifestyle and stay in the community," Venello says.

The case managers don't drive the clients to their appointments as a convenience to the clients. They do it to ensure that the client will show up for the appointment, she adds.

"We accompany them because they need to access service and there is a likelihood they wouldn't get there on their own," Venello says.

There is a 50% no-show rate at the hospital's mental health clinics, she says.

"These families often are disorganized and overwhelmed by all that is going on in their lives. The parents often have drug and alcohol problems. Without that intensive case manager or resource coordinator being there to give them structure, a lot of kids and families wouldn't make it," Healy says.

The case managers develop a close relationship with the clients and their family members.

"The program has been so successful because the clients and family members know that the ICM or RC is their advocate and has their best interest in mind. The relationship they develop is remarkably strong and trusting," Healy says.

Some people have been in the program since it started in 1987. "Case management is a very big part of these clients' lives, particularly those with no family or community resources. The people in the program are more compliant with their psychiatric treatment plan, take their medications, and go to their appointments. Having someone to guide them has made a big difference in their lives," Venello says.

When the program was begun, statistics showed that the intensive case management reduced inpatient stays and crisis intervention for the patients. After a few years, the state of Pennsylvania was so convinced of the value of the program it no longer required outcomes documentation.

"At first, we tracked the outcomes very closely; but within a couple of years, it became so clear that the program was doing what it was intended to that it was no longer required by the state that we report the statistics," Healy says.

*(Editor's note: For more information, contact **Terri Venello**, RN, at e-mail: terri.venello@crozer.org, or **Colleen Healy**, MA, MBA, at e-mail: colleen.healy@crozer.org.)* ■

Program keeps unfunded patients out of the hospital

Program saves $500,000 a year in two years

An outpatient case management program aimed at frequent utilizers of hospital services has paid off for Seton Healthcare.

For the last two years, the initiative saved the hospital $500,000 annually in decreased utilization and identifying funding sources for the patients, according to **Pat Beal**, LCSW, outpatient case management supervisor for Seton Healthcare network and Seton Northwest operations manager.

The hospital developed an outpatient case management program as a result of a meeting of about 100 Seton staff from a variety of disciplines who brainstormed on how to better manage underfunded and unfunded patients.

Patients who meet the criteria for referral to the program are those who lack funding and have had three inpatient admissions or six emergency department (ED) visits during the past 12 months.

"The goal of the program is to find out why these patients keep coming into the system and to develop ways to better manage their care and keep them out of the system," Beal says.

The outpatient care management program started with one social worker and now has a staff of five FTEs. "The program has been very successful. We have plans to increase the staff by one person per year," she reports.

The program won the Innovative Program of the Year from the Society of Social Work Leadership in Healthcare in Texas.

The financial department compiles a list of patients who meet criteria for the program. Referrals also come from hospital clinicians, ED staff, local physicians, and word-of-mouth.

Case management staff review the patient records to determine what the diagnoses were, then call the patient or send him or her a letter explaining the service.

When a patient agrees to participate, a care manager does an intensive psychosocial assessment and develops goals for managing their care.

The case managers help patients find a primary care physician, obtain medication, and apply to government and community sources for health care funding. They may arrange transportation to physician visits and help them sign up for other services, such as food stamps.

In one case, the hospital purchased an insulin pump for a patient who was frequently hospitalized because her blood sugar was unmanageable.

The case manager may accompany patients on doctor visits to be a second set of ears, to help the patient express his or her concerns, and to make sure the patient follows through with the physician's recommendations. "We work to change patient behavior and to make sure that they get better care for their disease. Their quality of life improves dramatically as they become more self-sufficient and in control of their health," Beal says.

Each case manager in the outpatient case management program manages the care of 30-35 patients. "The patients flow through the service. Once we have made significant impact so they no longer utilize the emergency department, we wean them off the program and open up that spot for a new patient with high utilization," Beal says.

Another Seton program provides outpatient care management for high-risk obstetrical patients who are being seen in city clinics or in private physician offices. These patients may have gestational diabetes, may be very young or very old, have a chronic disease, or be incarcerated.

"Since we have begun case managing these patients throughout the pregnancy, we've seen dramatic improvements in outcomes for the babies and their mothers," Beal says.

The case managers make sure the patients have transportation to their doctor's appointments and call them if they miss an appointment.

The hospital also works with private physician offices to identify pregnant patients who may be at risk for complications.

The case management department has created "passports," folders with information on pregnancy and a needs assessment form to fill out. The assessment includes questions about substance use, domestic abuse, history of multiple births, lack of insurance, and whether the mom is considering putting her baby up for adoption.

If they answer "yes" to any question, they are called by the high-risk obstetrical program. The case manager may see the patient in person, or refer them to counseling or an anti-smoking program.

"We are helping physicians by providing resources to meet the psychosocial needs of the patients they're managing. It's a great service for the doctors and another way to ensure that the pregnancy has a good outcome," Beal says.

The program is open to patients with insurance or other funding as well as those who have no funding. ■

Hospital uses bright blue to nurture bottom line

Unscheduled inpatients targeted

A procedure for obtaining copays and deductibles from unscheduled inpatients during their hospital stay is the latest in a series of successful collections initiatives at Hillcrest Medical Center in Tulsa, OK, says **Julie Willis**, patient access manager.

In line with the growing industrywide focus on nurturing the bottom line, the hospital looks for "every possible way" to bolster collections, she notes. "You have to be creative in the way you do it."

While registrars have been asking scheduled inpatients and outpatients to fulfill their financial obligations during the preregistration process since at least 2003, Willis says, the process for collecting from unscheduled patients began in March 2004.

After financial counselors verify the insurance and determine the copay and deductible for an unscheduled patient, she explains, they fill out a sheet with this message: "Dear Patient: Upon dismissal from the hospital, please stop by registration and pay your deductible or copay. The amount of ____ is due now. We accept cash, check, or credit card." It instructs patients to direct questions to the two financial counselors who handle the process.

The message, printed on bright blue paper, is delivered to the patient's room by a registration representative, Willis says. "We have found that colored paper works well."

At the same time, she adds, the registration rep gives a notice — this one printed on hot-pink paper — to the nursing staff to put on the patient's chart.

The information on the patients' financial responsibility is provided to the nursing administrator, Willis says, in the hope that he will remind nurses to bring patients by the registration desk as they are being discharged.

In some cases, however, all the registration reps have to do is ask, she points out. "It's amazing how [some patients] will just come down and pay $1,000 or $1,500."

Other times, Willis adds, the patient's family comes by later and pays the bills. If the person says he or she doesn't have a credit card or a checkbook, she notes, the registrar leaves a self-addressed envelope and asks that the payment be mailed.

The first year the process was put in place, she says, it brought in an additional $76,000; and in 2005, an extra $109,000.

"In the past, we wouldn't have gotten any money from any of them [at the time of service]. By collecting this, we've reduced the number of bills that need to go out for copays."

Willis says she has observed that the way the patient is approached seems to make a difference in whether a payment is made or not. "When [the registrar] is a cheerful, high-energy person, [he or she] seems to collect more than a timid person."

About 34% of patients who are handed the notices end up paying the copay or deductible before they leave the hospital, she says. "We feel there are more we could collect from. The next step is to have someone assigned to follow up again, probably with a telephone call or an additional visit to the room."

In the case of scheduled patients, Willis notes, staff also call and verify benefits and get copay information, and fill out a colored sheet to let registrars know how much to collect when the patients arrive.

Registrars inform patients of the copay or deductible amount when they call to gather demographic information, she adds. "That works very well," Willis says. "Sixty-eight percent of our total collections are from scheduled patients."

Total collections in 2003, the year staff began asking for upfront payment, amounted to $852,000, she says, compared to $679,000 in 2002. By 2004, total collections — for inpatients, outpatients, and the emergency department — equaled $1.3 million, Willis says.

A self-pay coordinator works all the self-pay accounts, both inpatient and outpatient, she notes. "Basically, with nonurgent procedures, we give the patient an estimated price. The person has to be able to pay a minimum deposit and sign a promissory note."

Self-pay patients receive a 30% discount, Willis adds, if they pay half the bill up front and the balance in 30 days. "A lot of them take advantage of that."

If the person is unable to pay the minimum deposit, she says, there is a medical review to determine if the procedure can be postponed until the financial obligation can be met, or if an exception will be made. ■

(Continued from page 86)

from a local Goodwill Store and tap into the health system's rescue fund to provide needed care for indigent patients. Money from the fund is contributed by private donors in the community and by the Carondelet Health Network staff.

The fund has a limit of $250 per patient, which can be used for medications, transportation back home or even, in some cases, lunch, Coburn reports.

"We go to every extent possible to find relatives or friends who can provide a home for these patients. If we find ourselves against a brick wall, the homeless have the choice to live on the street," she says.

Homeless patients often end up staying in the hospital for a long time if they're too sick to be on the street. The hospital can discharge patients to shelters, but they have to be ambulatory and they have to be able to take care of themselves, Coburn says. "As a religious organization, we go the extra mile. We're really creative and do whatever is necessary to ensure that the patients get the care they need."

In the case of homeless patients who need an IV infusion, the hospital typically keeps them until the treatment regime is finished unless the social workers feel that the patient would come in every day for treatment if discharged to a shelter.

"There are laws that require us to provide a safe discharge for patients, and we do everything in our power to comply. We keep patients if we have to and give them the services they need," Coburn says.

The attending physician sends a referral to social services when a patient is homeless and is likely to have post-discharge needs. "The doctors know some of these patients, and they feel like they can treat them and discharge them. They let us know if we can help in any way," she says.

The social worker interviews the patient and completes a needs assessment. "We do assessments on 80%-90% of the homeless patients. The exception is when the doctor knows them and they have minor problems," Coburn reports.

The social workers try to determine how patients got to be homeless, whether they came to Tucson that way or lost everything after they arrived.

"Each homeless person needs a care plan of his own. We try to tap into whatever resources we can, depending on the needs of the patients and where they want to go after discharge. Our social workers have to be really familiar with community resources, and we do everything we can to get the patients the care they need," Coburn explains.

Some nursing homes in Tucson will take patients with Medicaid pending. In addition, Arizona has a program that provides long-term care for eligible patients. "We have negotiated with nursing homes to take patients and to bill us. They will accept patients only if they know there is a discharge plan. When the hospital gets full, it's cheaper to put them in a nursing home and pay for it," she says.

The social work staff try to empower people to take care of themselves.

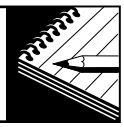
If patients have an addiction or a behavioral problem, the social workers try to tap into local behavior health programs, a task that has become more challenging as mental health resources have dwindled.

Staff can provide bus passes and taxi vouchers to take patients where they want to go.

"It depends on the severity of the illness and the severity of their social situation. Some patients don't want any help. They say they just want this one problem treated and that they aren't asking for help," Coburn says.

*[For more information, contact **Winnie Coburn**, RN, CPHQ, e-mail: wcoburn@carondelet.org.)* ■

GUEST COLUMN



Get a handle on your discharge process

Engagement of all relevant disciplines is necessary

By **Patrice Spath**, RHIT
Brown-Spath & Associates
Forest Grove, OR

Hospital discharge must be viewed as a process rather than an event — which should start as early as possible, *i.e.,* at the point of admission if not before. Case managers should identify the patients who are likely to need an actively managed hospital stay and post-hospital health and social care services. Where there is a potential for long-term support or skilled care, systems must be set up as soon as possible to ensure a smooth transition at the time of hospital discharge. Good patient assessment and

Figure: Discharge Process Checklist

	Yes	No
Discharge policies and procedures are regularly evaluated and updated as needed.		
There is a person responsible for discharge coordination for every patient, and the care team knows who this person is.		
Discharge is an actively managed process that begins at the point of admission (if not before).		
Roles and responsibilities of care team members involved in various aspects of patient discharge are clearly defined.		
Weekend and evening discharges can be easily arranged.		
A copy of the hospital's discharge policy is made available to patients and their relatives on admission.		
Readmission trends and causes of readmissions are monitored.		
Delayed discharges and causes of delays are monitored.		
Improvements in the discharge process are based in part on feedback from patients and their relatives.		
A sufficient range of post-hospital services are available in the community (bed-based care, care at home, housing-based options, as well as intermediate care).		
Your organization has a strategy in place to ensure that there will be sufficient residential and nursing home places to meet future demands.		
Caregivers have access to an overview of all resources available in your local service area — across primary, community, social and acute care — for older people's services.		
Effective partnerships have been developing for working across the whole system of health and social care in your community.		

Source: Brown-Spath & Associates, Forest Grove, OR.

discharge planning depends on a mixture of different professional skills. This requires engagement of all the relevant disciplines, e.g., therapists, nurses, social workers, physicians, as well as the patient and their relatives.

Effective partnership among all members of the health care team is the foundation of good care coordination practice for hospitalized patients. How well hospital discharges are managed is a good litmus test of how the different parts of the whole system work together. The problems concerning hospital discharge fall into a number of categories; these include discharges that:

- occur too soon;
- are delayed;
- are poorly managed from the patient/family perspective;
- are to potentially unsafe environments.

Insufficient capacity within local residential and nursing homes is cited as a common reason for hospital discharge delays. The hospital must work with local agencies to consider what is needed in the community and project future needs. Engagement of community leaders and providers should be actively pursued. More capacity may not necessarily mean "more of the same." Reimbursement policies make it clear that an acute care hospital is not the best place for an older person while further assessment or services are put in place. Health care capacity plans for the community should include interim, nonacute care options for these patients. Fundamental rebalancing of existing services toward rehabilitation and promoting independence may be needed.

Another common reason for discharge delays occurs where placements of choice are not immediately available. Remaining in the hospital until the desired placement becomes available is not appropriate. The definition of choice must be qualified by choice of what is suitable and also available. Finally, managing capacity is not simply about beds or buildings. For example, delays in carrying out patient assessments can arise when appropriate staff are not available at the right time or with the right skill mix. Discharge delays also can occur when services such as transport, home medical equipment delivery, pharmacies, or diagnostics are not available at evenings and weekends.

Effective partnership among all members of the health care team is the foundation of good care coordination practice for hospitalized patients. How well hospital discharges are managed is a good litmus test of how the different parts of the whole system work together.

To understand the impact of proactive discharge planning, it is essential that each unit monitor relevant performance indicators. For example:

- average length of stay;
- percent of patients discharged on their predicted day of discharge;
- discharge patterns by day of week and time of day;
- percent of patients seen by a case manager;
- percent of patients discharged by 11 a.m. (or recommended discharge time established by the hospital);
- number and type of patient complaints about the discharge process;
- number and type of delayed discharges.

Having the right processes in place to accurately record the number of discharge delays and the reasons why they occur is an essential first step to tackling the causes of delays. It is not possible to resolve problems if the reasons for delays are not well understood. Don't just report the number of discharge delays. The information needs to be broken down into meaningful categories. Also, the data must be as accurate as possible so that energy is directed at tackling the problems, not disputing the figures. Categories for reporting discharge delays include:

- internal hospital factors (e.g., the timing of patient rounds; waits for diagnostic test results; delays in a home assessment);
- coordination issues (e.g., communication and arrangement of health and other community-based services, availability of transportation);
- capacity and resource issues (e.g., limited availability of care options; placement difficulties at post-discharge care facilities; availability of a home care provider);
- patient/family involvement/choice (e.g., lack of engagement with patients and family members in decisions about their care; patient/family refusal to accept post-discharge recommendations).

Vulnerable or elderly patients often have continuing care needs after being discharged from acute hospital care in order to resume independent life at home. Successful transition from hospital to home requires good discharge planning, with collaboration between the hospital, relatives,

CE *questions*

21. How much increased revenue resulted from the University of Iowa Hospitals and Clinic's Healthcare Benefits Assistance Program in 2005?
    A. More than $19 million
    B. More than $500,000
    C. More than $5 million
    D. More than $10 million

22. What is the limit per patient on money from the rescue fund contributed by the staff at Carondelet Health Network?
    A. $250
    B. $75
    C. $150
    D. $500

23. What is the caseload of the intensive case managers at Crozer-Chester Medical Center?
    A. 18 children or 18 to 24 adults
    B. 20 children or 30 to 40 adults
    C. 15 children or 20 to 30 adults
    D. 30 children or 40 to 55 adults

24. What is the criteria for patients in the outpatient case management program at Seton Healthcare Network?
    A. Unfunded, three or more ED visits or one hospitalization in a year
    B. Unfunded, six or more ED visits or three hospitalizations in a year
    C. Unfunded, 10 or more ED visits or four hospitalizations in a year
    D. Unfunded, four or more ED visits or two hospitalizations in a year

Answer key: 21. A; 22. A; 23. A; 24. 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. **The semester ends with this 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. ■

and community health services. A measure of collaboration could be "hospital bed days lost due to delayed discharge" — the higher the figure, the poorer the collaboration. An indicator of good discharge and appropriate rehabilitation could be "percentage of patients admitted from their home who return to their own home."

Feedback from patients and family members also can serve as a valuable measure of discharge planning performance. To be useful for performance improvement purposes, this feedback must provide sufficient detail about the patient's experience. One question about discharge planning on a multi-question patient satisfaction survey is not adequate. If you ask patients to rate their satisfaction, you tend to get very positive responses, despite the fact that you know things aren't perfect. In addition to surveys, it is helpful to gather more information through focus groups and face-to-face interviews.

Below are examples of questions that would provide greater depth of information about what happened during the discharge process from the patient's perspective:

- Were you (or your family) personally involved in making plans for your discharge?
- How satisfied were you with preparations for your discharge?
- Did you receive adequate discharge assistance from hospital staff?
- If you did not return home when you were discharged,

— were you (and your family) given a say in where you would go after leaving the hospital?

— prior to you leaving the hospital, did your family (or nonfamily caregiver) visit the place where you would be going?

- When you were discharged, did you know the name of the physician or other health care professional who would be caring for you after leaving the hospital?
- When you were discharged, were all arrangements finalized for any treatments or care you would need after leaving the hospital?
- When you first saw your physician (or other health care professional) after leaving the hospital, did he or she have enough information about your hospital stay to be able to care for you properly?

Successful discharge planning is *not* achieved by finding a single silver bullet. Realizing an effective patient discharge process involves a series of small, incremental improvements in clinical, operational, and strategic planning aspects that accumulate to have an impact on the efficient transfer of patients from one setting of care to another. Use the checklist in the **Figure (p. 93)** to evaluate your current process. The "no" answers represent improvement opportunities. ■

AMBULATORY CARE
QUARTERLY

Will centers make money with the move to APCs?

Start analyzing now to prepare for change

As surgery centers begin to analyze how a new reimbursement system, if passed, would affect their income and bottom line, they are finding that future changes will be a mixed bag.

The Department of Health and Human Services (HHS) previously announced that HHS will propose including all outpatient surgical procedures on the list of approved procedures for ambulatory surgery centers (ASCs), except for those that department officials think would pose a significant safety risk in a center and those that would require an overnight stay. The change would come as part of the implementation of a new ASC payment system in 2008.

In other action, a bill was proposed that would expand Medicare coverage for ASC services and revamp the ASC payment system. It would set the ASC reimbursement rate at 75% of the hospital outpatient department (HOPD) rate with transition provisions so that payments for specific procedures would not decrease.

Generally, ASCs would be paid in the same manner and for the same things as HOPDs, including implants. However, ASCs would not be paid for outliers, graduate medical education, or capital.

On one hand, some specialties may experience significant reimbursement decreases. On the other hand, cases that previously were performed at a loss or were borderline may actually be profitable with new APC rates, says **Caryl A. Serbin**, RN, BSN, LHRM, president and founder of Surgery Consultants of America and Serbin Surgery Center Billing, both in Fort Myers, FL.

"An increased number of groups lead to more equitable reimbursement in most cases," she says. Instead of nine payment groups for surgery center procedures, they will be reimbursed under hundreds of ambulatory payment classifications. Serbin spoke on preparing for the new reimbursement system at the most recent annual meeting of the American Association of Ambulatory Surgery Centers.

The current nine payments groups aren't very logical because so many different types of procedures are put into the same group and reimbursed at the same rate, Serbin says. "This is one of those rare times that what the hospital is doing makes more sense," she says. "We don't want to follow all that they do, but we'd like to follow right behind them" with this.

To analyze the effect of a new system, which takes effect in 2008, consider the following suggestions:

• Determine future direction for cases that wouldn't be profitable.

For those cases whose profit appears threatened under the new reimbursement system, work with your physicians, suggests **Mike Pankey**, RN, MBA, administrator at Ambulatory Surgery Center of Spartanburg (SC). "We're trying to get them to get their costs down so we can continue to do the procedures," he says.

For those procedures that won't be able to become profitable, Pankey is working to move those cases to the hospital that is in a joint venture with the center. "I hate to lose cases, but if I do 100 cases where I've lost money on every case, I can't continue to do that," he says.

Surgery centers can't bill for some outliers that hospitals can, Pankey says. "Hospitals are seeing an increase of approximately 3% a year, so the distance between hospital reimbursement and ASC reimbursement is now increasing," he says.

Pankey points out that ASC reimbursement is flat until 2008 due to a freeze on Medicare rates. "We want to market to new physicians where [proposed] changes have brought some procedures into the positive area for us and expand our services in those areas, and we want to minimize those areas where we may be losing money in cases," he says.

• Determine impact with managed care.

Serbin is putting together spreadsheets for every managed care contract to determine where they are paying in comparison to 75% of the HOPD rate. "On paper, it looks like significant increases for many procedures we're doing," she reports.

One of the biggest changes will be the types of cases her centers can perform, Serbin says. "It will in the long run allow us to do more procedures, including ones we always knew we should do, such as lap chole, which weren't cost-effective to do in an ASC," she explains.

Orthopedics is another example, Serbin notes. She and other managers have been upset about how they've been reimbursed in terms of supplies and overall time. With the proposed system, "it's going to end up making it a fairer payment system for us," Serbin says. If surgery centers are able to charge for implants and other orthopedic items, as hospitals are, this will help some surgery centers to receive more reimbursement per cases, sources say.

While you can begin discussions with managed care companies about the new system, they are ill-prepared to deal with it now, Serbin warns. "There's no commitment one way or another," she says.

Centers that currently are reimbursed based on group rates will see a huge impact that will

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 in small, rural hospitals
- Deciding which case management model works best for you
- Case managers' roles in end-of-life issues
- Making your way through the Medicare maze

make their rates more equitable when the system changes, Serbin reports. If you have contracts that will continue into 2008, you must open the dialogue with payers, she says. Be sure you know your case cost prior to beginning negotiations, Serbin advises. "Say, 'We suspect a new system is coming. How will you handle it?'" she suggests. "Put language in there that says, 'When we have a change, you will follow Medicare guidelines.'"

The centers reimbursed on a percentage of charges won't see an impact, Serbin points out. "If you're in a percentage of billed charges, you don't want to have that conversation," she says. "You're better off, and you hope they will ignore it."

Pankey uses a physician-hospital organization to contract with managed care organizations. "I'm meeting with my rep to make sure she's aware of the changes coming and having her get in touch with payers regarding any changes to contracts," he says.

• Update your fee schedule.

Similar to her analysis of managed care rates, Serbin is beginning to look at how HOPD rates are paid, what expenses are grouped, and how she might begin to make a fee schedule based on these items. While surgery centers currently seek 350%-500% of Medicare rates, this range will have to be adjusted under HOPD rates, probably to a 350% markup of HOPD rates, she predicts, "Five hundred percent would be way too high," Serbin says.

Pankey says he hopes his contracts will hold up in under the new system, "but if Medicare goes down, the contract goes down," he says. "You can't just look at Medicare. You have to look at the whole payer mix and fee schedule." ■