HOSPITAL CASE MANAGEMENT™

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

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Take the lead in helping to remedy ED crowding, diversion, boarding

Efficient patient throughput is the key

Hospital case managers are in a unique position to help their hospitals find solutions to the ever-increasing problem of overcrowded emergency departments (EDs), emergency department diversions, and boarding admitted patients in the emergency department because there are no available beds, says **Toni Cesta**, PhD, RN, FAAN, vice president of patient flow optimization for the North Shore-Long Island Jewish Health System. Cesta is responsible for patient flow at 15 hospitals in the Great Neck, NY-based system.

The recent Institute of Medicine report on the crisis in emergency care points out what many people in the hospital field have known for some time — that patient flow is a tremendous issue that affects patient care, patient satisfaction, quality, and safety, she adds.

The report, *Hospital-Based Emergency Care: At the Breaking Point,* one of three reports issued in June by the Institute of Medicine of the National Academies (IOM), calls for action to bolster the country's emergency care system.

The demand for emergency care grew by 26% between 1993 and 2003 according to the report. Over that same period, the number of EDs in the nation's hospitals declined by 425. In 2003, nationwide, ambulances were diverted 501,000 times — an average of once every minute — because of overcrowded EDs.

"Emergency department overcrowding in a typical situation isn't due to what is going on in the ED; it's caused by patient flow deficiencies on the hospital side," Cesta says. "Patient throughput is a complicated problem affected by many factors, and it's an issue where case managers can show their value to the hospital."

The IOM calls for hospitals to reduce ED crowding by improving hospital efficiency and patient flow. It recommends that the Joint Commission on Accreditation of Healthcare Organization reinstate strong standards for

ED boarding and diversion and that the Centers for Medicare & Medicaid Services develop payment and other incentives to discourage ED boarding and diversion.

Patient flow standards from the Joint Commission, which went into effect Jan. 1, 2005, call for hospitals to develop plans to overcome any roadblocks to efficient patient flow throughout the hospital.

"The standard requires hospital leaders to identify all of the processes critical to patient flow through the hospital system from the time the patient arrives, through admitting, patient assessment and treatment, and discharge and includes such issues as diagnostic, communication, and patient transportation procedures," says **Dennis S. O'Leary**, MD, president of the Joint Commission.

The IOM report expressed concern about "emergency room boarding," in which patients who have been admitted are held in the emergency department, sometimes for more than 48 hours, because there is not an available bed.

"It's a huge patient safety issue. We know from a quality of care and patient safety perspective that these patients don't get the same level of care in a holding pattern as they do in a regular inpatient bed. The emergency department isn't ramped up to deal with inpatients, and they don't focus on them," Cesta says.

Patient flow roadblocks occur on the front end with delays in getting patients worked up, diagnosed, and treated and on the back end when discharge is delayed, she says.

Hospital case managers have numerous opportunities to expedite patient flow in the emergency department, on the floor by assuring that procedures and other patient care take place in a timely manner, and by starting discharge planning early in the stay so the patient and family are prepared when the discharge orders are written. **(For a look at how one hospital improved the patient discharge process, see p. 132.)**

"Case managers are in the best position to assume the role of seeing that patient flow is efficient. The nurses are busy providing daily care. The physicians aren't on the floor all the time. It's one of the value-added functions that case managers can bring to the table," Cesta says.

Hospitals need to have a good understanding of what is delaying patients getting through the emergency department portion of the stay, and consequently should be aware of the roadblocks throughout the hospital stay, she notes.

Cesta advises case management directors to look at all of the inpatient care processes and determine the inefficiencies. Develop metrics for assessing inpatient throughput and the roadblocks to a timely discharge, and then come up with ways to alleviate the problems and track the outcomes, she says.

Case management software programs that can help you track delays and other throughput issues are essential in today's hospitals, Cesta adds.

Cesta suggests that the case management leadership approach hospital administration to invest

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in software to help identify where the process gaps are.

"Collecting data helps us see where process improvement needs to take place. We have to identify where the gaps occur so we can fix them. We need data to help us understand where the inefficiencies are so we can take steps to correct them," she says.

Hospitals need ED case managers who are dedicated only to the emergency department, Cesta says.

ED case managers can identify patients who are inappropriate for admission and arrange post-discharge community services, such as home health care and nursing home admissions. They can facilitate the care of the appropriately admitted patients and their transfer to the floor.

"People are starting to realize that hospitals need case managers in the roots of entry to the hospital, especially the emergency department," Cesta says.

A case manager in the admitting office can be helpful if the majority of the hospital's patients come through there, she adds.

Cesta recommends that hospitals determine periods of high occupancy in the emergency department and assign a dedicated case manager to the ED during those hours. Typically, the high-volume times occur between 11 a.m. and 11 p.m. or noon and midnight.

If social workers are assigned to the emergency department, a social worker could come in earlier to fill the morning gap, she suggests.

"Patients who are potential social admissions or who have other psycho-social problems may wind up sitting in the emergency department overnight. The social worker could come in the next morning and deal with those issues," Cesta says.

Bed management and bed tracking are important as hospitals tackle patient flow solutions.

Bed-tracking nurses are dedicated to making sure that beds are turning over in a timely fashion and that housekeeping is alerted when a bed is available for cleaning.

Backlogs in admissions occur when housekeeping doesn't know when to clean and nobody lets admitting know when a bed is available, Cesta adds.

"The case manager's role has always been to optimize each day that patients are in the hospital and to see that things get done in a timely fashion," she says.

But in many hospitals, case managers are spending their time doing insurance reviews, instead of concentrating on moving patients through the continuum, she adds.

"Most case management departments are understaffed because the administration doesn't understand the value of case management, and we in the field haven't quantified what the case manager does," she says.

In addition to discharge planning so patients can go home in a timely manner, hospital case managers should work to make sure patients get the tests and other procedures they need to begin treatment.

High occupancy rates

Cesta cautions that timeliness of services is likely to slow down and lengths of stay increase when a hospital's occupancy rate exceeds 90%.

"High occupancy rates put the hospital at a significant disadvantage in terms of patient flow. There are the same number of MRI machines, stress machines, laboratory workers, and more patients lining up for the services. Patients end up waiting longer for tests and staying in the hospital longer," she says.

The reasons for the emergency department crisis are numerous, with roots in the health care crisis affecting the country, Cesta points out.

Many times patients can't access their physician in a timely manner. If they have a sick child and it's after hours, they're likely to be directed by their physician to seek care in the emergency department.

Many patients, particularly Medicaid recipients, use the emergency department as their first source of health care, automatically going there instead of to a clinic or a primary care physician. Then there's the problem of the uninsured who don't make enough money to afford health care insurance and come to the emergency department for care. Federal guidelines say that hospitals can't turn them away.

As the number of emergency diversions has gone up, length of stay has started to creep back up incrementally, Cesta says.

"Hospitals are being hit with a double whammy. More people are going to the emergency department, and the hospitals are experiencing longer inpatient stays. The problem is compounded by a shortage of community resources. There is a lack of nursing home and subacute beds, and many patients may not have home care benefits," she says. ■

Initiative aids discharge planning, throughput

Families alerted to discharge day early in the stay

Before Mease (FL) Dunedin Hospital began a Six Sigma project to improve patient discharge, only 45% of patients whose discharge orders were issued by noon were being discharged by 1 p.m.

Since the discharge process was tweaked, 90.2% of patients with discharge orders issued by noon are leaving the hospital by 1 p.m.

Before the project started, the hospital was experiencing increasing hours of emergency department (ED) diversion.

"When we examined the problem, we found that it wasn't necessarily because of the size of the emergency department but was due to the throughput of patients," says **Carol Przybycin,** BSN, MS, director of Six Sigma deployment for BayCare Health System, with headquarters in Clearwater, FL.

At the time the project began, 54% of patients were leaving after 1 p.m. and 66% of the hospital's emergency department diversion hours were occurring after 1 p.m.

"In our data collecting, we found out that there were a lot of times when we were not discharging patients in a timely manner. There was a huge standard deviation between when we got the order and when the patient was actually discharged," says Przybycin.

The purpose of the project was to improve patient throughput and free up inpatient beds for patients coming into the hospital. They worked to increase inpatient capacity by removing the roadblocks to discharging patients in a timely manner, she adds. "If we have the order by noon and the patient is discharged by 1 p.m., it opens up beds for incoming patients and allows a more predictable work flow for the hospital team."

Since 82% of the 173-bed hospital's patients are discharged to home, the project focused on patients going home, rather than those being placed in post-acute care.

Members of the interdisciplinary team included the director of nursing, the director of case management, nurse managers, the case management manager, and the clinical resource coordinator, an RN case manager who manages the course of treatment for the patient. The champion of the team was the vice president of patient services, who assisted the team in removing any barriers it encountered.

The team gathered data on patient discharges and used brainstorming and other techniques to identify variables to discharge and to come up with ways to overcome the barriers.

The team found that three factors were involved in most of the discharge delays: transportation home, consults for post-discharge care, and communications between the staff members and between the staff and the patient and family.

Lack of transportation home was the cause of a delay in discharge in the majority of the patients.

"Most of the time, the family members who take the patient home work during the day. If they don't know in advance that the patient isn't going to be discharged, they can't make arrangements ahead of time," Przybycin says.

The second biggest cause of delays was a delay in orders being written for hospice or home health consultations. Often, the orders were being written the day of discharge.

"With good discharge planning throughout the stay, the case managers can anticipate the needs before discharge. We worked to insure that the consults were ordered in a more timely manner," she says.

The team found that sometimes the patient load of the nurse caring for a particular patient interferes with discharge being a priority.

"We looked for other staff who could be available to help with what the patient needs to be ready for discharge," Przybycin says.

For instance, the charge nurse, the discharge nurse, or a peer on the unit should be able to pick up the responsibility of insuring the patient's discharge needs are met, she says. The hospital's admissions nurse is available as a resource to help with the discharge when the primary nurse is busy with other things.

Lack of communication often was the biggest factor in discharge delays, regardless of the actual cause.

"Often the problem was a lack of awareness on the part of the nurse, the patient, or the family that the patient was going to be discharged that day. Our communication circle was not sophisticated enough to have ongoing discussions about discharge from the time the patient was admitted. We made improvements to that process as well," Przybycin says.

The team came up with ways to emphasize the importance of making discharge planning a priority, including getting medications, tests, and

therapy ordered.

To make sure that everyone focuses on discharge efforts, the team added a space for discharge planning information at the top of the daily written report sheet that the nursing staff uses to document information that should be passed along from shift to shift.

"We put anticipating discharge planning right there on the main trigger list with information about risk for falls and special monitoring needs, so that the staff will be focused on it at all times," she says.

The hospital now requires nurses to write the anticipated date of discharge on the report and document that they have talked to the patient and family members about discharge plans and transportation home.

The team developed a pink sticker for the progress notes that physicians use to alert the staff of any discharge needs the patient may have and the anticipated time frame for discharge.

"The doctor often writes the discharge plan in the progress notes, but the nurses were not attuned to reading that and passing the information along. This allows the staff to interact with the physicians sooner, rather than waiting for the discharge order," Przybycin says.

The team scripted an interaction about discharge for the nurses to use as they talk with the patient and family.

The interaction is to take place at five designated times: admission, the day following admission, when the doctor indicates a discharge plan, the day before the planned discharge occurs, and the day of discharge.

In addition, team members created a poster, which hangs in each patient room, alerting the family to their role in discharge planning.

"We wanted to create awareness for the patient and family that we are focusing on a timely discharge," she says.

The poster includes information on the Four Cs of Discharge Planning: communication with the family and caregiver; coordination of care after discharge; collaboration between the patient, family, and hospital; and collaboration between the family and hospital.

"To serve you better and to accommodate other patients, our goal is to complete discharge within one hour of the time the physician writes the order," the poster reads.

The hospital has standardized the discharge process and discharge planning from floor to floor.

The patient care nurse, social worker, charge nurse, clinical resource coordinator, and physicians, if available, attend a daily discharge meeting with the discharge nurse.

On occasion, with orthopedic patients, the physical therapist also will attend to give an update.

"The key piece is that whoever is in that meeting needs to make sure that they communicate with the other nurses, the patient, and the family," she says.

All of the patients are discussed on a daily basis, to differing degrees depending on their readiness for discharge, and the information is communicated to the bedside nurses, who take any action necessary.

"By doing this, we are able to identify if the doctor hasn't written the order for the consultation, and we can request on the patient's behalf to get the orders in place. This way, we don't have five sets of orders for consults coming in at once on the day of discharge," she says.

The nurse on the day shift now knows that the discharge order is a priority and no longer waits for the change of shift for the discharge to take place.

"No matter what time that order comes in, we want everything in place so that the discharge can take place within the hour. We have improved from discharging patients within the hour 22% of the time to discharging them within an hour 45% of the time," she says. ■

Dedicated CM-SW team care for trauma patients

Coordination begins at ED, ends discharge

When traumatically injured patients are admitted to Dartmouth-Hitchcock Medical Center, the only Level 1 Trauma Center in New Hampshire, their care is coordinated from arrival in the emergency department (ED) through discharge by a social worker and a case manager team dedicated to the Lebanon, NH, hospital's trauma program.

As the social worker for the trauma team, **Nancy Trottier**, LICSW, MSW, meets the patients and family members in the emergency department whenever possible and follows them throughout their hospital stay.

She works closely with **Elizabeth Williams**, RN, BSN, CRRN, who manages the care of the patients as soon as they are transferred to the trauma service floor.

"Trauma case management is a very dynamic

role. Every patient is different. Two people may have the same injuries but very different support systems and other factors that affect their length of stay and recovery. We work closely together to make sure the patient's and family's needs are met during the hospital stay and that the patient can be safely discharged," Williams says.

Williams, who has a background as a certified rehabilitation registered nurse, focuses on the clinical aspects of care. Trottier concentrates primarily on the patient and family's psychosocial needs and financial challenges.

Both pitch in and do whatever is necessary to make sure that the patient and family members have the support and information they need. "What makes it work is that there is not a sense of 'I do this and you do that'. We see each other throughout the day and constantly work together to make sure that everything the patient needs is being addressed. We've got to be working closely together to quickly assess the patient's needs and do what is best for the patient and family," Trottier says.

Both attend trauma service rounds once a week, updating the team on family support and other psychosocial and financial issues that may be barriers to discharge.

Typical patients referred to the trauma care management team have injuries involving one or all of their extremities, with or without a traumatic brain injury or spinal cord injury. Some patients transfer from the ED to the critical care unit and are later transferred to the floor, while others are admitted directly to one of the specialty surgical units.

Due to the nature of trauma, many of the patients are 18 to 40 years old, with a history of high-risk behavior. About 40% or more are uninsured, a statistic that also is associated with risky behavior.

"Many of our patients are involved with law enforcement and the court system. Substance abuse is a major factor in a lot of the traumatic injuries," Trottier says.

Coordinating their care is challenging because of comorbidities, financial and psychosocial issues that make the discharge planning more complicated, she adds.

"What is important is that these patients and family members get the support they need and have the medical information clearly presented to them from the beginning. We know it takes time for them to really comprehend what has happened, and we make sure they get information quickly about the potential outcomes so they can begin the process of adjustment," Trottier says.

Trauma patients present different challenges from other patients because their hospitalization happened quickly after an unexpected event, Trottier points out.

"These people were not planning to be here at all. They were at work or driving and all of a sudden, they are seriously ill. When things happen so quickly, it's a challenge for the patients as well as their families and friends," she adds.

In addition to whatever psychosocial issues the family had before the accident, a traumatic injury creates more psychological issues as patients and family members deal with the losses created by their accident, Trottier says.

"We work with survivors of an accident in which family members sustained fatal injuries, and we work with people who have lost limbs or been paralyzed by the accident. It's an emotional time, and the families need a lot of support," she adds.

The support often begins in the ED when Trottier meets the family as soon as they arrive.

"I connect with the family as soon as possible and get to know them. It's helpful for them to have a familiar face. The nursing staff changes, the therapy staff changes, but we are there for them throughout their whole hospital stay," Trottier says.

Many of the family members arrive from out of town and are not familiar with the hospital or the community. Trottier helps them learn their way around the hospital and find a place to stay overnight.

She helps the family contact other relatives or friends who can be with them and calls in the hospital chaplain or a priest if the family agrees.

"One of the most important things is to find support for the family member, a relative, or a friend if possible who can add to the support we can offer them," Trotter says

As the patient is transferred to the critical care unit or the floor, Trottier lets the nurse know that family members are here..

"In many cases, the patient was not with the family member when the trauma occurred. They could have just gone to work that morning and the family could be in the emergency room waiting room without knowing what is going on," she says.

At Dartmouth Hitchcock Medical Center, case managers are assigned by physician service.

Trottier and Williams work primarily with patients being treated by the trauma services surgeons, both general surgeons and orthopedic surgeons who treat adults and older teenagers.

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They average between 12 and 15 patients at a time, although in summer months, when traumatic injuries are more likely to occur, the census on the unit could be higher.

"A lot of the case management activities involve forward thinking, anticipating the needs of the patient in the future," Williams says.

She begins by looking at what the patient's injuries are, what their post-discharge needs are likely to be, as well as what financial resources and support systems the patient has.

"I try to form a plan in my head before I meet the patient so that when they ask questions, I'll have some answers. It's part of the trust-building process. The patient has suffered a huge loss, and if they are getting information from someone they trust, it helps to understand what is going to happen in the hospital and throughout the continuum of care," Williams says.

Williams' case management activities involve a lot of troubleshooting, determining the patient's needs, finding out what the patient's payer source will or won't cover, and determining what should be happening to facilitate a speedy and safe discharge.

"We may need to get the patient help with medication or get him into a rehabilitation facility. A lot of times, the patients can't be discharged to home because of the physical environment and we have to find a discharge destination," she says.

The needs of trauma service patients vary depending on their home situation, family support, and financial resources. The length of stay hinges on the diagnosis, the extent of the injuries, comorbidities, and other issues, such as drug addiction.

"Some patients are here longer than they should be because they have a lot of other challenges and we have to make sure they have a safe environment after discharge. Some don't have a home. Others are unemployed with no financial resources but need post-acute care, and in some cases, the family isn't willing to help the patient after discharge," Williams says.

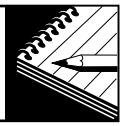
Patients 18 or older who sustained a head injury and can't legally make their own decisions have to have a guardian appointed for them.

"These patients have to have someone to act on their behalf. Sometimes, we have to go through the state to get a guardian appointed because they have alienated their families," Trottier says.

The team may help uninsured patients apply for Medicaid or other programs that can help with their care, a process that is complicated when the patient is of legal age but is too severely injured to make his or her own decisions.

"Family members can't sign a document for an adult unless they have guardianship, and severely injured patients may not be able to do so. It's a cumbersome, emotional process that may involve the court system and is complicated," Trottier says. ■

GUEST COLUMN



Where does the time go?

How CMs can successfully manage their time

By **Patrice Spath**, RHIT
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Forest Grove, OR

Case managers have a lot going on every day. Phones are ringing, pagers buzzing, people you need to talk with. Coordinating care for complex patients is knowledge work that often requires deep concentration. And deep concentration requires periods of uninterrupted time. What happens when case managers don't have time to concentrate on their work? It takes longer to solve problems and accomplish the tasks. Staff members who often *feel* busy all the time may not notice that not much is getting done. If you find staff saying they are feeling constantly busy or they leave work wondering just what they were able to accomplish, it is time to teach them how to take control. Busy-ness may be blocking your case managers from accomplishing their work.

While people like to pride themselves on their ability to multitask, trying to do two (or more) things at once actually reduces cognitive functioning. Multitasking isn't always a bad thing. However it can take a toll if the tasks require concentration. Complex tasks that require attention to detail are poor candidates for multitasking.

The more often case managers switch between activities, the longer it will take to complete any one of them. Each switch can eat up between five and 30 minutes of their time. To change tasks, an individual must mentally close out one activity and return to the other activity and re-create their train of thought to remember exactly where he or she was. If a person has been away from a task for more than a short while, he or she may need

to reorganize materials and regain concentration. The worst switches are those caused by interruptions — random events that pull case managers' attention away from the work and break their concentration. If interrupted for more than a couple of minutes, it's going to take most people some time to regain their concentration.

As director of the case management department you won't be able to eliminate the need for some multitasking among your staff or stop all interruptions, but you can help people gain more control of their workday. Good time management has always been an important skill, but for case managers it is essential. Factors such as high inpatient occupancy rates, shorter hospital stays, and information overload are putting the squeeze on case managers to get much more done each working day. Time management involves analyzing how staff time is being spent and then prioritizing different work tasks. Activities can be reorganized to concentrate on those that are most important. Various techniques can be useful for carrying out tasks more quickly and efficiently, such as information handling skills, communication skills, delegation, and daily time planning.

Be clear on priorities

Before case managers can successfully manage their time, they must be thoroughly familiar with their job description and with what they should and should not be doing. Any ambiguous responsibilities must be clarified. The precise role of case managers, their objectives, and performance targets should be clearly articulated by the manager. Everyone must know what is expected of them and these expectations should be in writing.

It may be helpful for case managers to keep a diary or log sheet for a period of at least two weeks to see how they spend their time. The manager and staff member should jointly review the log sheet entries, discussing questions such as:

- How many of the case manager's activities were planned and how many were unplanned?
- How accurate was the planning — did tasks get completed in the time allowed?
- How much time was spent on routine activities that could be delegated?
- How often did interruptions divert the case manager from his or her tasks?
- At what time of the day does the most work get accomplished?

The manager should assist the staff in determining how to use their time more efficiently. Split problem areas into the Enemy Without and the Enemy Within. The Enemy Without includes external factors beyond the case manager's control, such as mistakes or inefficiencies in other departments, unexpected extra tasks, and complicated patient/family situations. The Enemy Within is personal inefficiency and includes poor planning, lack of assertiveness in saying "No" to people, and putting off unpleasant activities.

Confront the time enemies

Tackling the Enemy Without may require the setting of service level agreements that detail what each department expects from case managers and improving interdepartmental communication. Interpersonal tensions or inefficient work practices in other departments may need to be addressed. Tackling the Enemy Within requires that case managers are taught to make more constructive use of their time. This can include better planning techniques, such as:

- spending five minutes each morning reviewing the day's activities and adjusting priorities as circumstances arise;
- building slack time into the schedule so that too many tasks are not constantly competing for the case manager's time;
- having a backup plan for contingency situations. Decide which tasks can be dropped, who can be called to help out, and who will need to be notified if the case manager is delayed by other activities.

The manager can help staff members prioritize their time by ranking tasks in order of importance. Try to be objective and avoid ranking highly those tasks that the case manager enjoys the most but are not that vital. The 80/20 Rule, also known as Pareto's Principle, has enormous meaning for the daily tasks of case managers. This rule says 80% of a person's time is spent doing things that are probably not as productive as the other 20%. Discover which of the case manager's activities are the "vital few" and separate them from "the trivial many."

In some circumstances, it may be appropriate to delegate some case management tasks to other people. The manager should be involved in determining those tasks and supporting the delegation process. Assess which tasks can be assigned to someone else. Regular routine tasks not requiring clinical expertise, such as completion of forms or report photocopying, should be handed over to clerical staff. Tasks that can be delegated to staff in

other departments will require some negotiation between the case management director and other managers. Do staff members in the other department have the time and willingness to do the task? Are employees in the other department knowledgeable and competent to perform the task? Can the task be easily integrated with activities already assigned to the other department? Before beginning these discussions with other departments, the case management director should feel confident that his or her staff members are managing their time effectively.

Review how work is done

Help case managers find solutions to work inefficiencies so they can accomplish more goals. Complex tasks can be broken down into manageable bits. Arrange work to avoid task hopping. It's best to concentrate on one thing at a time. It can be more productive to batch similar tasks together rather than multitask.

Encourage case managers to avert unwanted interruptions as much as possible. Answering machines and voice mail were invented so that we wouldn't miss important calls. However the technology also can be used to protect important opportunities for concentration. Unless case managers are expecting a critical message, let voice mail pick up calls. Then staff members can choose when to return calls. Confer with payers and other facilities to establish a set time for sharing information. Most people are willing to set a mutually convenient time if they realize it's helping you help them get the information they need.

Make sure the meetings that case managers attend are really necessary and, if running one yourself, be sure it is well organized. Can some meetings be eliminated or shortened? Meetings are most productive when only the people who need to be there are there, they know what they're doing, and they leave with a clear idea of what to do next. Does the meeting need to happen at all? Can the same result be achieved with a phone call or two? If case managers are required to a attend meeting, make sure you know why their presence is needed and what's expected of them.

Case management productivity depends on good tools and effective environments and on using them both well. It can be overwhelming for case managers to get their work done. Try tackling one of the time-wasters each month. Pick one where you can make a positive change right now to keep your staff motivated. ■

CE *questions*

9. According to the Institute of Medicine, by what percentage did emergency department visits increase between 1993 and 2003?
   A. 15%
   B. 30%
   C. 26%
   D. 14%

10. After a Six Sigma initiative to improve the discharge process at Mease Dunedin (FL) Hospital, was percentage of patients with discharge order issued by noon are actually discharged by 1 p.m.?
   A. 75.2%
   B. 55.6%
   C. 83.6%
   D. 90.2%

11. Many of trauma patients managed by a case manager-social worker team at Hitchcock Medical Center fall into what age group?
   A. 18 to 40
   B. 20 to 30
   C. 65 or older
   D. 25 to 45

12. In the first year of the CMS-Premier Pay-for-Performance pilot project, Kettering Medical Center received a bonus of $92,085, thanks in part to the hospital's clinical documentation specialists, who review the charts daily for documentation and quality.
   A. True
   B. False

Answer key: 9. C; 10. D; 11. A; 12. A.

CE instructions

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

AMBULATORY CARE
QUARTERLY

Joint Commission's 2007 National Patient Safety Goals will revamp emergency department nursing practice

New goals require you to involve patients in their care, give medication list on discharge.

Do you identify patients at risk for suicide? Do you give patients a list of their medications? And do you encourage patients to report safety risks?

These are some of the changes you'll need to make to comply with the 2007 National Patient Safety Goals from the Joint Commission on Accreditation of Healthcare Organizations.

"To be safe, health care has to be done as a team activity, and the patient is arguably the most important member of the team," says **Richard J. Croteau**, MD, the Joint Commission's executive director for strategic initiatives.

Here are the new requirements with strategies for each:

• **Encourage patients to report concerns about safety.**

At McKay-Dee Hospital Center in Ogden, UT, "We urge patients to be involved with their own care and to report safety concerns by statements in their discharge instructions, which are reviewed with them," says **Kayleen L. Paul**, RN, CEN, care center director for emergency, critical care, and trauma services. "We also include the name and phone number of our care manager on every discharge instruction and urge them to give us feedback about any issue they might have."

The statement invites questions about ED care, medications, follow-up instructions, or aftercare. "We are considering adding the specific word 'safety,'" she says. For example, the statement may be changed to read, "If you have any questions or concerns about your care or safety in the ED or about your follow-up care, please call . . ."

Patients have called the ED to confirm that they received the correct medication, says Paul. "The prescription medication may look different in size and color than the dose we gave, and patients have called to clarify that it's the right medicine," she says. "It's always been a case of the pharmacy using a generic and not a medication error, but I always praise people for their attention to important details."

Invite patients to report safety concerns by handing out a brochure, posting a sign, or discussing this at triage, recommends **Darlene Bradley**, RN, CNS, CCRN, CEN, MICN, FAEN, director of emergency/ trauma services at University of California-Irvine Medical Center in Orange.

Inform patients

"Inform the patient that health care staff are interested in safety and will listen to any concern the patient would like to address," she says. "Letting the patient know that the organization wants to provide a safe and secure environment opens the door for that discussion to continue."

Patients have voiced safety concerns about wet floors and the risk of infection if an infiltration occurs with intravenous infusion, says Bradley. "Patients also question blood transfusions, disease transmission, and fear of receiving the wrong blood," she adds. "When patients witness caregivers complete the double-check to validate the right blood for the right patient, the anxiety subsides."

• **Involve patients in their care.**

At Barnes-Jewish Hospital in St. Louis, ED nurses explain that they need to ensure that the correct patient is getting the correct treatment, says **Jennifer Williams**, MSN, RN, BC, M-S CNS, CEN, CCRN, clinical nurse specialist for emergency services. "We inform the patients on

arrival that care providers will ask them their name and date of birth while confirming it with their armband many times, specifically before medications and procedures," she explains.

• **Identify patients at risk for suicide.**

If your ED is caring for psychiatric patients, surveyors will expect to see that patients are assessed for risk of suicide, says Croteau. "The fact is that patients sometimes do commit suicide in the ED itself." In addition, if patients aren't admitted, there is a risk of suicide after they leave the ED, he adds.

Many EDs are reporting significant increases in the number of psychiatric patients, notes Croteau. "Any time the volume goes up, it puts pressure on available resources, but that is not a reason to do the right thing," he says.

Don't miss suicide risk

Assessment of suicide risk may be a major challenge for many EDs, says **Kathleen A. Catalano**, RN, JD, director of health care transformation support for Perot Systems, a Plano, TX-based provider of information technology services and business solutions.

"EDs are prepared for that if they are one of the behavioral health receiving centers, but otherwise, they may not know how to deal effectively with the issue."

At McKay Dee, the ED collaborated with the psychiatry department to put crisis workers in the ED to help with assessment of psychiatric patients. "Some patients are clearly brought in for a crisis evaluation by family, police, or themselves," says Paul. "For other patients, especially trauma and those involving medication 'mistakes,' the nurses are trained to have a high index of suspicion and frequently consult the crisis worker."

Suicide risks often are identified by the person accompanying the patient, says Bradley.

To assess suicide risk, she suggests using quick assessment tools such as "SAD," an acronym standing for:

— Sex, because women attempt suicide three times more often than men;

— Age, because individuals 19 years or younger and 45 years or older are at greater risk;

— Depression, which is a good indicator of suicide risk.

"The presence of the three criteria may warrant a closer assessment by the nurse," says Bradley. She also recommends the "PERSONS" assessment:

— P, previous attempts at suicide;
— E, ETOH (alcohol abuse);
— R, an inability to think rationally;
— S, a lack of social support;
— O, an organized plan for the suicide;
— N, no spouse;
— S, a chronic or disabling sickness.

ED nurses routinely screen patients for violence and abuse at Barnes-Jewish Hospital, says Williams. "Perhaps the biggest challenge is continuing to ensure consistency in screening our patients," she says. "We need to ensure that every patient is provided the same level of screening from every ED nurse."

• **Give patients a complete list of medications on discharge.**

"Provisions for listing all medications at discharge may be a challenge for many EDs," says Bradley. Give patients a wallet-size card with the medications, dose, frequency, and purpose for each medication listed, she recommends. "All patients should be encouraged to carry such

COMING IN FUTURE MONTHS

- How case management can take the lead in quality initiatives
- Case management's role in medication reconciliation
- How to develop case management competencies for your staff
- Why documentation enhancement should be a priority

tools," Bradley says.

A medication list could be given to patients with discharge instructions or as a wallet-sized card, says Paul. "If given as a pocket card, there needs to be some way to change doses, or add and subtract medications," says Paul.

Having an electronic medical record that can update medication lists with each visit is key to doing this list effectively, says Bradley. The University of California-Irvine's ED uses a "problem list" in which care problems and medications are listed.

Upon arrival to the ED, the listing is updated and verified with the patient. At registration, the list is automatically printed for every patient. As the care is completed, changes to the list are entered and validated.

Medication interactions

"The list is available to all health care providers in the hospital and the clinics who are caring for the patient," says Bradley. "The printout at discharge is then used to evaluate the drugs, review side effects, and analyze for drug interactions." Errors, potentially harmful drug interactions, and discrepancies are identified through this process, she says.

Patients don't realize that vitamins, minerals, and herbal supplements can interact with other medications and can be hazardous, and these often are not reported to ED nurses, says Bradley. "Patients that frequent multiple institutions including doctor's offices and hospitals generally get a medication for each complaint," she says. "The failure to report these and document the types, doses, and frequency of use can be a significant hazard to the health of the individual." ■

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. ■

CRITICAL PATH NETWORK™

Specialists track core measures, documentation, DRGs

RNs work on team with case managers, social workers

Kettering Medical Center has found a solution to the challenges case managers face when they have to manage the daily care of patients, plan for discharge, work with insurance companies, and ensure that the hospital is meeting its targets for quality initiatives.

The case managers, who are part of the hospital's quality department, work as a team with the hospital's clinical documentation specialists, highly experienced bachelors- and masters-prepared nurses who review the charts every day for documentation issues and quality measures.

"Case managers can't do everything. If case managers are responsible for core measures, documentation, and making sure the DRGs are correct on top of their other duties, some things are likely to get dropped by the wayside. I don't see how case managers can do justice to quality initiatives along with their other responsibilities," says **Liz Wise**, RN, BSN, administrative director for clinical quality at the Dayton, OH, medical center.

At Kettering, case managers are unit-based and work as a team with the social workers, coordinating the care for between 20 and 30 patients. The clinical documentation specialists also are unit-based and work as part of the team.

Case managers focus on the plan of care and are responsible for utilization review, working with the insurance company and reviewing quality issues for the hospital's peer review committee.

"The case managers look at the whole aspect of patient care, including avoidable days and denials, and work closely with the insurance companies and physicians," Wise says.

Using the hospital's electronic case management system, the case managers review the charts daily and refer any quality issues to the hospital's peer review committee.

The clinical documentation specialists work closely with the case managers and social workers and review the charts every day for quality issues and documentation.

"When we created the clinical documentation specialist position in 2001, their responsibility was to review the charts for documentation and making sure that patients were placed in the right DRG. They work closely with physicians and make sure that everything that is done for the patient is documented," Wise says.

Now, the clinical documentation specialists are a vital part of Kettering Medical Center's pay-for-performance initiatives.

Kettering Medical Center, which includes Kettering Memorial Hospital and Kettering-Sycamore Hospital, was one of the top-scoring medical centers during the first year of the Premier-CMS pay-for-performance demonstration project. The hospital received a total of $92,095 in the first year of the demonstration project. Preliminary estimates show that the hospital will receive a significantly larger amount for the second year of the program, according to Kettering Medical Center's clinical quality decision support department.

In addition, the hospital participates in the Surgical Infection Prevention (SIP) and Surgical Care Improvement Programs (SCIP) through CMS and Premier.

"The clinical documentation specialists were looking at charts anyway and talking with physicians. We added the pay-for-performance project to them," Wise says.

During their chart review, the unit-based clinical

documentation specialists make sure that the core measures are being followed and that medication reconciliation sheets are completed correctly.

"They work together as a team with the case managers and work closely with the nurse managers and the charge nurses. They follow the patients closely, working with the physicians to make sure they have everything documented in the chart," she says.

Clinical documentation specialists

The clinical documentation specialists are RNs with at least a bachelor's degree and at least five years experience in a specific disease area and who have served in a leadership role for two or more years. Other requirements include excellent computer skills, an understanding of databases, and the ability to conduct educational sessions and PowerPoint lectures.

"This is the only way that someone would know the right questions to ask the physicians. We wanted them to be very knowledgeable clinically so they'll be looked at as a credible resource," Wise says.

For instance, she points out that the medical records staff can code only using what a physician writes on a chart, not what is on the laboratory reports or outcomes from other procedures. That's why it's essential that the people doing documentation review have extensive knowledge of that diagnosis and be able to interpret the reports, Wise says.

"If someone doesn't know and understand the diagnosis, they can't read between the lines and ask the physician to clarify his documentation to reflect the true condition of the patient," she says.

The clinical documentation specialists' standard caseload is 20 to 30, the same as case management.

"They are responsible for knowing every patient on their unit. They review all new charts each day and never go longer than three days without reviewing the chart," Wise says.

They review the charts of patients whose diagnosis falls under the core measures every day. If the DRG does not have a core measure, they review the chart every three days.

On a daily basis, the clinical documentation specialists typically review six to 10 new admissions.

The clinical documentation specialists communicate frequently with the case managers and the social workers and work closely with them to make sure that all the quality measures are being documented.

For instance, if a case manager is reviewing the chart of a patient with congestive heart failure and sees that some of the core measures have not been followed, she'll mention it to the clinical documentation specialist, who will make sure the measures are followed.

The nurses, case managers, and clinical documentation specialists have an informal meeting every morning, and sometimes more frequently, to make sure that everyone on the team is aware of who is new on the unit and what issues are outstanding. Each unit has an interdisciplinary team meeting at least once a week.

In June 2005, the hospital started a concurrent documentation analysis process to supplement the retrospective quality measures analysis turned in for national ratings.

"When hospitals turn in their data for national performance improvement projects, it may be six to nine months before they get the score. By that time, in most cases, changes in Medicare have already taken place," Wise says.

The hospital uses its electronic case management software to gather the information concurrently.

"Within 30 days of a patient's discharge, the information that was collected concurrently is then validated in our working system and sent electronically to the Ohio Hospital Association, the Centers for Medicare & Medicaid Services, or the Joint Commission on Accreditation of Healthcare Organization and Premier. This way, we have to input the information only once, and that is concurrently," she says.

By collecting data on a concurrent basis, Wise can run daily, weekly, and monthly reports showing variances by unit and by physician.

"We are able to take that back to the unit and talk about it on a daily basis, during team meetings between nursing, the case manager, and the clinical documentation specialists. We are able to send the report monthly to the service line, physicians, and nursing management so every unit knows how many variances it had that month," Wise says.

At Kettering Medical Center, the charts stay on the units for 24 hours after discharge, giving the clinical documentation specialists a chance to review the discharge to make sure everything is in order.

The case managers and the discharge planners complete all data before the chart is moved. They make sure that the information is the same in the medical records sheet and the discharge summary.

"In the past, the charts were picked up the day

of discharge and if all the documentation wasn't complete, the case managers couldn't always follow through until the chart was already in medical records. This saves a trip to the medical records department to make sure everything is documented," she says.

The physicians like having the charts stay on the unit longer so if they don't get the discharge summary completed the day of discharge, they know the chart will be available the next morning.

Making the chart more complete saves time in medical records because no one has to re-compile the chart, Wise says. ■

Create an environment where CMs can thrive

Increased caseloads, high stress can cause burnout

If you want to recruit qualified case managers and retain the ones you have, you have to create the kind of environment in which caring nurses want to work, **Catherine Mullahy**, RN, BS, CRRN, CCM, suggests.

"Case managers want what every employee wants — mutual respect, a collegial environment, and the ability to make a difference. Stress is a big factor. If the department is crowded with files everywhere and it looks like chaos, people aren't going to want to work there," adds Mullahy, president of Options Unlimited, a Huntington, NY-based case management company.

Finding good case managers is more of a problem now than ever before, as the shortage of registered nurses has intensified, Mullahy points out.

"The nursing shortage is to the advantage of nurses. Everybody, regardless of the health care setting, is having problem finding good nurses and keeping them," Mullahy says.

Historically, case management positions have been attractive to experienced nurses because they typically were a Monday-through-Friday job.

"Hospital case managers didn't work on weekends or on the evening shift in the past. That has changed, particularly with the number of people who can't get to the hospital to pick up their family members during the day but can get there in early evening hours," Mullahy says.

Case managers in all settings are experiencing the same thing — increased case loads, increased stress on the job, and the feeling that no matter what they do, they are not making a difference," she adds.

Because of the critical nursing shortage, some hospitals are paying bedside nurses more than an experienced case manager can make, Mullahy says.

"While money is a factor in any job, many nurses may not be the primary breadwinner in their family and may be willing to take less money to work in a less stressful environment," she points out.

Employers need to look at creating the kind of environment that attracts nurse case managers, she says.

If you are offering a high-stress, high-volume job with a lot of telephoning calling and little patient interaction, you may find it difficult to attract qualified case managers, she says.

"When I talk to colleagues about interviewing for a new position, I suggest that they need to interview the employer as much as the employer needs to interview them," she says.

Job assets

Here are some job assets that case managers are looking for:

- a reasonable caseload;
- a professional environment;
- the ability to attain continuing education;
- support for attending educational conferences;
- cost-sharing for certification.

If you want to keep the staff you have, be careful about insisting that your case managers work long hours, she suggests.

"In professional categories, a certain amount of overtime is expected, but some case managers are expected to work overtime and are not given compensatory time off. Employers may abuse a nurse's affinity to not leave the patient in the lurch," she adds.

Consider splitting shifts or allowing job sharing to retain experienced case managers who have young families at home, Mullahy suggests.

Providing a shift for working moms who can come in at noon and work until 8 p.m. could attract highly skilled case managers who can't work 9 a.m. to 5 p.m., she says.

"The more flexibility you have with working hours, the greater capacity you have to attract staff," she says.

Job sharing is another possibility, she suggests. If two nurse case managers share the load on a unit, it gives them the flexibility to work on a shift that suits them.

RN case managers went into nursing to work with patients. They are likely to burn out quickly if the majority of their job involves paperwork or computer work, Mullahy points out.

"If they don't have much interaction with patients or family members, their job is not going to satisfy their desire to make a difference to people. Nurses like that kind of collaboration and feeling like they are making a difference," she says.

Make sure that the management of your hospital understand the value of case management and act accordingly to provide your staff with the salary, benefits, and recognition they deserve, Mullahy says.

If case management positions are being cut and other positions at the hospital aren't, it's possible that the case managers haven't done a good enough job of articulating what value they bring to the organization, she says. "If employers understood the value of case managers, they'd add more of us instead of cutting back."

Hospitals are faced with a shortage of resources, a shortage of money, and increasingly complex patients, and that's where case managers can be a tremendous asset, she points out.

"Case managers assist with better management of patients across the continuum. They expedite discharge and follow the high-risk patients beyond the hospital. Case management can demonstrate real value to the hospital administration," she says. ■

Week is an opportunity to recognize your staff

National Case Management Week, Oct. 8-14, 2006, is a great opportunity to make sure that the case managers on your staff feel appreciated and that their contributions are recognized by the entire hospital, suggests **Connie Commander**, RN, CCM, ABDA, CPUR, owner and president of Commander's Premier Consulting Corp and national president of the Case Management Society of America.

"It's up to the director of the case management department to speak up and see that the case managers get the recognition they deserve. They should talk to the hospital administration and make sure that the case management department is recognized for its contribution to the hospital," she adds.

At many hospitals, case managers get lumped into National Nurses Week because they are a smaller department, but they also need some recognition of their own, points out **Catherine Mullahy**, RN, BS, CRRN, CCM, president of Options Unlimited, a Huntington, NY-based case management company and a former president of CMSA.

"Case managers should be included in hospital presentations, such as Nurse of the Month. But in addition, hospitals should put case managers in the spotlight so that everyone in the hospital is aware of what we do and the contributions we make to the hospital," she says.

Case managers often assume that other people on the hospital staff understand their role, and if they don't understand correctly, they don't always bother to set them straight, Mullahy says.

Case Management Week is the perfect opportunity to educate everyone in the hospital about the role of case managers and their contributions, she adds.

"Like anything else, recognition for case managers is a shared responsibility. The employers have the responsibility, but the case managers have the responsibility, too," she says.

Talk to the hospital administration about National Case Management Week and make sure they understand what case managers do and how valuable they are to the hospital, Commander suggests.

"Case managers are not just about decreasing length of stay. They are an invaluable part of the treatment team, but they're not going to be recognized by being a little voice in a big hospital. They need to find a champion in the administration," she says.

Put posters up in the cafeteria where everyone can see them.

"This makes the consumers as well as the staff aware of case managers and what they do," Commander says.

Commander tells of one hospital case management department that hosted an ice cream social and poster presentation to kick off National Case Management Week.

The hospital staff enjoyed ice cream and had an opportunity to learn what case management could do for them, she adds.

Commander suggests asking the administration to host a luncheon for case managers and present the case managers with a pin or a certificate.

"What case managers want is to be recognized. They want a certificate and a pat on the back that shows that their boss's boss appreciates what they are doing," she says. ■