HOSPITAL CASE MANAGEMENT™

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

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ED case managers can improve throughput, reduce denials

Staff should be dedicated to the department

If your hospital doesn't have case managers who are dedicated to the emergency department (ED) and who work during peak hours, you're missing an opportunity to improve patient throughput, reduce denials, and cut down on patients who return to the ED over and over.

Unless there is a dedicated case manager in the ED, the emergency department staff may not contact one at a time when he or she can truly be beneficial, such as determining if a patient meets the level of care for inpatient admission or if the patient could be treated in another level of care, says **Lorraine Larrance**, BSN, MHSA, CPHQ, CCM, manager with Pershing, Yoakley & Associates, a Charlotte, NC, health care consulting firm.

"In most facilities I visit, the era of emergency department case management has not come fully into its own," Larrance adds.

Most facilities do have inpatient case management staff who can be called when there is a complex patient whose needs are outside the expertise of the ED nursing staff to handle, she says.

"This doesn't fulfill the truly effective role of an emergency department case manager. The emergency department nurses are focused on their scope of work and don't always realize the value of what case managers can lend to them in their management of patients or overall for the organization," she says.

Case managers typically are among the few people in an acute care setting who have extensive knowledge of what happens across the continuum of care and who can make sure that the patient is treated at the appropriate level of care, says **Peter Moran**, RN, C, BSN, MS, CCM, ED case manager at Massachusetts General Hospital in Boston and president-elect of the Case Management Society of America.

"Case managers can provide a tremendous service in the emergency department by looking beyond the patient's immediate needs. They can

help patients and family members learn to navigate the health care system and find the resources they need in the community. They know what criteria must be met for admissions and what documentation needs to be in the chart. They recognize what patients need consultations and what discharge needs are likely to be," Moran says.

Case managers are in a unique position to make sure that patients who are admitted to the hospital qualify for acute care, adds **Toni Cesta**, PhD, RN, FAAN, vice president, 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.

"Access-point case management is critical in today's hospitals. Depending on where the majority of patients enter the hospital, a hospital may need case managers in the admitting office as well as the emergency department," she says. **(For a look at one hospital's admissions management program, see related article on p. 4.)**

Case managers are knowledgeable about admission criteria and discharge planning and can help physicians determine the appropriate level of care from the beginning, rather than having it determined 12 to 24 hours later on the inpatient unit, Larrance says.

"By the time the inpatient case managers get to the patient and medical record, it may be too late to change patient status, particularly if the patient could have been admitted in observation status," she adds.

Emergency department case managers can have a great impact on patient throughput by working with the ED physicians and nursing staff to get a patient who is borderline for inpatient admission managed in the emergency department and avoiding an unnecessary admission, Larrance says.

Once a physician determines that a patient should be admitted, case managers should be brought into the process before the paperwork is done to make sure that the patient meets criteria and that the diagnosis supports the admitting diagnosis, Cesta says.

Case managers in the ED have an opportunity to affect the patient's length of stay by starting the patient assessment and facilitating the initiation of care, such as getting tests and procedures performed early on and making sure that appropriate patients receive the treatment covered in the core measures, such as antibiotic administration, Cesta says.

"Case managers in the emergency department can get a tremendous amount of good information by talking to the ambulance staff if the patient was picked up from home. They can meet with family and friends in the emergency department and share the information with the inpatient case manager," she adds.

They can talk to patients and family members about what they can expect during hospitalization and begin to talk about discharge options, Moran adds.

For instance, the family may think a short stay

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means a week and the physician actually means overnight.

If it appears that the patient will need post-discharge services, such as rehabilitation or home care services, ED case managers can start the ball rolling by finding out if the patient has a preference for services and setting up whatever screenings and services are necessary.

If a patient is likely to be discharged to a skilled nursing facility (SNF), the ED case manager can contact the facility and request the screening, rather than waiting for the unit case manager to do so the next day. Sometimes patients can be placed directly from the ED, depending on their needs and contractual agreements, Moran says.

In busy emergency departments like the one at Massachusetts General, case managers can be invaluable in helping place patients in an alternative level of care.

"A lot of times, the patients the case managers are dealing with may be chronically ill, but in terms of who is in the emergency department, they may be some of the healthier patients and can be moved to another level of care," Moran says.

For instance, a Medicare patient who insisted on going home from the hospital instead of spending time in an SNF may come back to the ED in fewer than 30 days. The patient doesn't need acute care but isn't managing at home and can be transferred directly to a SNF after evaluation.

"Case managers need to identify these kinds of patients when they come in and make sure the work-up is done so they can be moved. Keep them on the radar screen for the emergency room physicians, who may be distracted by sicker patients coming in," Moran says.

Moran frequently encounters families who are bringing in their loved ones with dementia or other conditions because they can no longer care for them.

"The families are burning out and desperate for help. The ED case managers can help them access assistance programs, such as elder services, meals on wheels, home health aides, or adult day programs. People don't know how to access these services. Part of the role of the emergency department case manager is to educate them," he says.

Case managers in the ED should review patients who are being transferred from other facilities to determine if their needs can be met at that facility, he adds. For instance, many acute rehab hospitals can treat patients with pneumonia but often transfer them to the acute care hospital for an evaluation. The doctors in the ED see a new pneumonia patient and put them in for a bed in the acute care setting.

"When this happens, I suggest that our emergency department doctor calls the doctor at the facility to see if the problem can't be handled there," Moran says.

Case managers have the opportunity to intervene in the case of patients who keep returning to the ED.

For instance, if a patient comes in with back pain, ED staff conduct an examination and an X-ray and, if there is nothing acute, give the patient pain medication and suggest a visit to a primary care physician. Many times, the patients can't get a doctor's appointment before they run out of pain medicine and return to the ED.

This is an opportunity for the case manager to intervene and get the patient an expedited appointment with the physician or a prescription that will last until they can see the physician. Patients who have additional ED visits seeking pain medicine can be labeled "drug seeking" when in fact they did everything they were instructed to do and the problem is access in the community, Moran says.

ED case managers can help get medication for patients who can't afford it and refer uninsured patients to someone who can help them sign up for public assistance.

"The bottom line is, hypertensive patients need to be sent home with medication, and if they don't have the money to buy them, they may come back when they have a stroke and the hospital's liability is much higher," he says.

Case managers in the ED can monitor variance data, such as delays in getting patients in beds, patients who can't afford medical equipment or medication, or patients whose physician sent them to the ED for what should be an outpatient test or procedure, Cesta says.

"They can identify barriers to care and work to overcome them on a case-by-case basis, then collect aggregated data to look for patterns where process improvement is needed," she says.

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Identify areas where a CM can have an impact

Staff the ED at peak hours of admission

It's not necessary to have a case manager in the emergency department 24 hours a day, seven days a week, and case managers don't necessarily have to screen every patient who comes into the ED, says **Toni Cesta**, RN, FAAN, vice president, patient flow optimization for the North Shore-Long Island Jewish Health System.

She recommends defining those hours in which the ED is busiest and assigning case managers accordingly. Twelve-hour coverage during peak hours should be sufficient.

"I've worked in a lot of hospitals with a tremendous volume in the emergency department, but even there, the number of people coming in the middle of the night didn't warrant having a case manager on duty," she says.

Consider staggering case management hours with the hours that social workers cover the emergency department, she suggests.

Case managers don't have the time to manage the care of all patients who come into the emergency department, adds **Peter Moran**, RN, C, BSN, MS, CCM, ED case manager at Massachusetts General Hospital in Boston.

For instance, diverting one patient from the ED to another level of care routinely takes four hours, he adds.

"It's not possible to see everyone. Case managers in the emergency department can be pulled in many different directions if you don't set priorities. There must be some mechanism to identify which ones need scrutiny," Moran says.

Patients who are high-priority may be the frail elderly, the homeless, patients who were medically discharged within 30 days, and the hospital's "frequent flyers."

Start by defining the purpose of your ED case management program, what areas the case manager should be expected to affect, and how the program will support the hospital's needs and goals, Moran says.

"Even more importantly, it is necessary to have systems to be able to identify patients who could benefit from case management interventions and a means of documenting the impact of the case management intervention," he says.

In a hospital with high occupancy and an overcrowded emergency department, one goal for ED case managers would be to divert patients to other settings. If the hospital's occupancy typically is low, a goal might be to get the patients admitted quickly.

You might want case managers to concentrate on determining inpatient vs. observation status or to help patients who come to the ED frequently find a primary care physician or other community resources to fill their needs.

"The role of the emergency department case manager depends on the needs of the organization," Moran says.

Once your program is established, set up a mechanism for collecting outcomes data to prove the value of ED case management to the hospital administration.

Cesta suggests collecting outcomes data in the following areas:

- decrease in denials due to improved patient status or proper documentation;
- reduction in the amount of time it takes to get patients admitted;
- reduction in turnaround time for patients who are treated and released;
- patient satisfaction with their emergency department experience;
- physician satisfaction with ED case managers;
- decrease in the number of visits by "frequent fliers";
- decrease in length of stay due to initiating treatment in the ED;
- decrease in length of stay due to starting discharge planning in the ED. ■

Value-based purchasing gives CMs chance to shine

OPPS final rule steps toward quality measures

The Centers for Medicare & Medicaid Services (CMS) took additional steps toward value-based purchasing and transparency in health care in the final rule for Medicare payment for outpatient services issued Nov. 1.

In the final rule for the Outpatient Prospective Payment System (OPPS), which takes effect Jan. 1, CMS also announced its intentions to tie outpatient payments to quality reporting in 2009 and announced additional measures on the inpatient

side that hospitals must report beginning in fiscal 2008.

"All of these changes spring from the idea of value-based purchasing and transparency in health care. CMS believes that patients have the right to make an informed decision about their medical care and that they should have easy access to the data they need to make that decision," says **Deborah Hale**, CCS, president, of Administrative Consultant Services, LLC, a health care consulting firm based in Shawnee, OK.

Outpatient quality measures and additional inpatient measures make it more important than ever for the hospital to implement strategies that facilitate appropriate care in a timely manner and that ensure that what is done for the patients is documented. These responsibilities often are delegated to case managers, Hale says.

The federal Deficit Reduction Act of 2005 calls for additional quality measures to be added to the Hospital Quality Data Payment Update Program and requires CMS to develop a value-based purchasing program by 2009.

"We have been hearing a lot about quality measures and value-based purchasing on the inpatient side. Because of the rapid increase in the cost of outpatient services, CMS wants to move in that direction for outpatient services as well," Hale says.

CMS estimates that between 2005 and 2006, hospital expenditures increased by nearly 12% due mainly to growth in the volume and intensity of services and that expenditures under the OPPS in calendar year 2007 will be approximately 9.2% higher than the estimated expenditures for 2006.

"The final rule places a lot of focus on the increase in payments for outpatient services. Because those services are increasing so rapidly, CMS is taking a close look at quality and cost measures," Hale says.

"In this final rule, we are taking one more step toward rewarding hospitals for providing quality care, not just in the inpatient setting but also in the outpatient department. The steps we are adopting today are a major step in our efforts to improve health care quality and help beneficiaries make informed health care decisions," according to **Leslie V. Norwalk**, Esq., acting CMS administrator.

In the final rule for the OPPS, CMS announced its intention to tie the Outpatient Prospective Payment System payments to quality reporting beginning in 2009 based on data from calendar year 2008. Hospitals that fail to report the quality measures would receive the OPPS update minus two percentage points in 2009.

CMS has announced its intentions to develop a set of cost and quality measures specifically for outpatient services. In the meantime, the initial OPPS quality measures will be some of the same measures that hospitals already are tracking for inpatient care. The initial set of outpatient measures includes the inpatient core measures for pneumonia, congestive heart failure, and surgical antibiotics.

"Many of the measures that hospitals are reporting for the inpatient core measures are the same as procedures that patients receive on an outpatient basis, such as appropriate administration of medications in the emergency department and antibiotics to prevent complications following surgery. If the hospital is collecting data on the inpatient side, they often find that the actual compliance with the core measures begins in the inpatient setting," Hale says.

The outpatient data are likely to focus on patients that hospitals don't capture in their inpatient data collection, such as those with pneumonia or congestive heart failure who might have been admitted under observation status or treated in the emergency department and released.

CMS initially proposed making quality reporting effective as of Jan. 1, but changed the date to 2009 in the final rule, according to Hale.

"Some of the people who commented felt like it would be unfair to start basing reimbursement on quality measures without giving the hospital a chance to improve. CMS agreed to wait and use the 2008 data," Hale says.

At the same time it announced the final rule for outpatient reimbursement, CMS announced the expansion of hospital reporting of quality measure for inpatient care, beginning in fiscal 2008 with the addition of four patient satisfaction measures and three new measures from the Surgical Care Improvement Project (SCIP) related to the process of care for patients undergoing surgical procedures.

Hospitals must report data on four measures on the 27-item Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), a survey instrument developed jointly by the Agency for Healthcare Research and Quality (AHRQ) and CMS.

The four measures, which measure patient perception of the care they received during an inpatient stay are:

- communication with doctors and nurses;

- responsiveness of staff;
- pain management;
- discharge information.

For the first time, in fiscal year 2008, hospitals will be required to report risk-adjusted outcomes measures to receive the full payment update. These include 30-day mortality rate measures for patients hospitalized with acute myocardial infarction or heart failure and following surgery.

"While hospitals can't control things that happen after discharge, a high mortality rate might be an indication that the patient was sent home too soon, or it could be related to quality of care or adequate documentation to reflect the severity of illness," Hale says.

CMS made no significant changes to the payments for patients who are treated in observation status, although the MedPAC subcommittee had suggested adding syncope and dehydration to the list of diagnoses that qualify for observation status, Hale says. Chest pain, congestive heart failure, and asthma remain the only diagnoses that qualify for separate observation payments. Observation payments for other diagnoses are packaged into the payment for the emergency department or surgical procedure.

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Initiative helps to improve patient throughput

Dedicated nurse is responsible for bed placement

An initiative that includes capacity alerts, "hall beds" used when the hospital is approaching capacity, and having one person responsible for coordinating bed placement has helped Spartanburg (SC) Regional Medical Center improve patient throughput and avoid being on emergency department diversion for more than a year.

"The key to our throughput initiative is having one person who owns the process and whose responsibility is to move the patients through the continuum. My goal is to be able to move patients out of the emergency department and into a bed as quickly as possible," says **Stacey Hodge**, RN, capacity management nurse for the hospital.

Before the hospital created the position in March 2004, department directors and case managers held lengthy bed meetings every morning to find a place for patients who were waiting for a bed. As ED case manager, Hodge attended the meetings.

"Emergency department patients were a priority, but nobody was looking ahead to see that we'd have other patients having surgery who also need beds. Bed utilization is a big concern of case managers, but it can't be the main thing they concentrate on. Everybody owned a little bit of the throughput initiative," she says.

When beds were needed, the directors called their floors to push the discharges, but it took them away from their other duties.

"When we came up with a good plan to place patients at the bed meeting, there was nobody to carry it out. Now it's my job to make sure that patient throughput flows smoothly," she says.

Hodge works closely with admissions and the nursing units throughout the hospital and reports to case management.

She monitors the hospital's bed board, a manual magnetic board that shows all the beds in the hospital with slots for the patient name, helping the clerical staff find the best bed for each patient.

"The bed board staff do not have a clinical background, and without clinical leadership they may not choose the bed that is best for the patient. I stay close to the bed board because it changes so quickly," she says.

For instance, if the orthopedic unit's capacity is high and a patient with a fractured hip comes in, a patient may have to be moved off the orthopedic floor.

"Our goal is to get the right patient in the right bed the first time so we don't have to move them around later," she says.

The clerical staff cover the bed board 24 hours a day, seven days a week. All requests for beds from physician offices, other hospitals, the ED, or the surgery department come into the bed board staff.

The bed board office gets a list of all patients being scheduled for surgery each day. "Depending on the procedures they're having, we can get a good idea of who is staying," Hodge says.

Each morning, the case managers on the floor send an e-mail alerting the bed board staff of anticipated discharge.

"This gives us a starting point to manage capacity for the day. If they have three beds available and we have five patients in surgery who need to go to that floor, I push to get more patients discharged," Hodge reports.

(Continued on page 11)

CRITICAL PATH NETWORK™

CMs partner with coders for appropriate documentation

A documentation enhancement project that pairs case managers and coders increased the Medicare case-mix index at North Mississippi Medical Center from 1.48 to 1.92 in six years for the Tupelo, MS, hospital.

The hospital's case managers take the lead in the documentation enhancement efforts.

Case managers are unit-based and typically coordinate the care of specific populations on that unit. This gives them an opportunity to develop a close working relationship with the physicians and to become specialists on coding for the diagnoses that most frequently occur among the population on their units.

"The case managers are in the charts every day, reviewing patient care, severity of illness, and intensity of service. It makes sense to teach them the coding language so they can teach the physicians in small increments," says **Jan Englert**, RN, director of outcomes management.

The documentation enhancement project has been an evolving process, says **Joellen Murphree**, RN, CPHQ, CCM, director of clinical quality and patient safety.

"Our goal is to produce documentation that gives a true picture of the patient in the coding language that will result in appropriate reimbursement for the care we provide. We are very conservative in our approach to the coding rules to avoid even the appearance of a violation," Murphree says.

The hospital began the documentation and coding enhancement initiative in 1998 by hiring a consultant, who conducted an extensive educational program on documenting and coding for the hospital's coders, case managers, and physicians.

The consultant presented an overview class once a week for four weeks for the case managers and coders and returned at intervals over a two-year period to work with the staff. The case managers and coders assigned to specific units reviewed charts with the consultant to become familiar with the nuances of coding.

"The goal was to enable the case managers to do concurrent coding on the nursing unit so the coder can just verify and add from the discharge summary," Murphree says.

After the initial educational sessions, the case managers began to code the diagnosis for Medicare patients in the charts on the nursing units.

Physician advisers

The coders would review the case managers' work and meet with all of the case managers once a month to discuss the cases in which they disagreed with the case managers' coding. When there were questions, they'd review the charts with the consultant.

"The coders began to trust the case managers, and, rather than redoing their work, they could validate it," Murphree says.

In the beginning, the case managers and the coders kept tally sheets listing problems they found in documentation. They gave them to the consultant, who based educational sessions with the physicians on where improvements were needed.

The hospital contracted with a retired medical doctor and a retired surgeon to be physician advisors for documentation. The physicians went through extensive training with the consultant and conduct retrospective chart review. They

meet periodically with the physician sections to talk about areas for improvement.

When case managers have questions for physicians about documentation or discharge planning, they write it on a lavender (the case management color) communication sheet and place it in the front of the chart. There is a space for the case manager to write a request for details, a space for physician comments, a notation of the current and expected length of stay for that DRG, and a section for discharge planning.

The physician advisors write a monthly documentation and coding newsletter in which they review the documentation required for a particular diagnosis or new requirements for documentation. For instance, one newsletter explains the difference in bacteremia, septicemia, systemic inflammatory response syndrome (SIRS), sepsis, severe sepsis, and septic shock and discusses what documentation is required for each.

Assuring correct documentation

When new physicians join the staff, they spend time with the physician advisors learning the correct method of documentation.

When the case managers began to take on the additional responsibilities of concurrent coding, the team drew up a list of responsibilities that would help them set priorities for their day.

"A case manager's first priority is not to be a concurrent coder," Murphree says.

Reviewing discharges scheduled for the day has the highest priority on the list, followed by beginning the process of finding nursing home, subacute, and swing bed placements; reviewing charts; determining needs for home health, DME, and outpatient services; discharge planning discussions with physicians and staff; reviewing patients readmitted within 30 days and denial appeals; then concurrent coding.

Assuring correct documentation is complicated by the fact that not every patient fits neatly into a category for a DRG, Englert says.

For instance, a patient may come into the emergency department and have an original diagnosis of pneumonia but upon further study, the physician may determine that the patient's symptoms actually are caused by an exacerbation of congestive heart failure.

These are two very different DRGs, she adds.

"We have to establish the principal diagnosis early on so we can document it correctly from the beginning. We must look at what is going on with the patient and document what we do appropriately so we get credit for what we have done for the patient," Englert says.

Physicians find documenting for Medicare patients frustrating because the clinical language they use and the coding language often are very different, Englert points out.

"Clinical language used by physicians and the coding language are hardly ever the same thing," she says.

For instance, the physician may write on the chart that the patient's hematocrit has dropped and order a transfusion, then document that the hematocrit came up. Unless he or she uses the words "blood loss anemia," the coder can't code the DRG or complication.

"Coders are not clinicians, and they can't make any clinical judgment. They can only put down what a doctor writes, even though it may be obvious that the patient has blood loss anemia. They can't surmise what the physician really meant even though the record suggests it," she says.

Physicians often document what the patient needs clinically, but their documentation may not reflect what CMS requires for reimbursement, Englert says.

"There is a huge frustration among physicians because they are doing a good job at clinical documentation but what they document isn't what we need to place the patients in an appropriate DRG and be reimbursed appropriately for the care given," she says.

The way physicians document to bill for their services is different from what CMS requires in the way of documentation for the hospital to be reimbursed for its services, Englert points out.

"The language physicians are required to use for their own billing is more clinically oriented. The hospital side of Medicare requires a totally different type of language. The doctors may have done a great job of documenting the patient's clinical condition but through these efforts have learned a different skill set: the language of DRG coding," she says.

"Appropriate documentation ensures the correct reimbursement for the care given. Just as importantly, it improves the physicians' outcomes in risk-adjusted measures such as mortality, morbidity, and complications and prepares them to be successful under pay-for-performance reimbursement," Murphree says.

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ED CMs improve throughput as patient advocates

Staff alert them to appropriate cases

When Cooley Dickinson Hospital (CDH) in Northampton, MA, put the first case manager in its emergency department, some of the staff were skeptical about how well the initiative would work, recalls **R.F. Conway**, MD, medical director of emergency services and chief of emergency medicine.

Now physicians, nurses, and even paramedics routinely alert the case managers when they encounter a patient who could benefit from case management services, he says.

"Emergency department case management is now a tight-knit, well-accepted program that is fully integrated within the culture of the CDH emergency department. We did a short outcomes study when we started the program, but it's been so successful that we haven't found the need to conduct a repeat study. We know that this is a program that works," Conway adds.

Two case managers work in the CDH emergency department Monday through Friday from 9 a.m. to 5:30 p.m. When a complex patient comes in on weekends, the emergency department staff call the case managers who are working the hospital floors.

Their duties range from ensuring that appropriate patients receive the treatment mandated by the core measures to assisting physicians in determining if an admission meets medical necessity or if the admission status is inpatient vs. observation. In addition, the case managers identify community resources that can help patients live safely at home and make follow-up calls to ensure that patients see their primary care physician.

"The emergency department case managers are patient advocates. They go to whatever level is necessary to make sure that the patients receive the treatment they need, have a safe discharge, and obtain follow-up medical care," says **Jan Lear**, RN, CCM, case management director.

The hospital started its ED case management program in October 1997, after a study showed that a significant number of patients who were being discharged from the emergency department were returning to the ED and being admitted to the hospital because they couldn't take care of themselves at home, weren't seeing a primary care physician, or had other issues that could be alleviated with case management, Conway says.

"We determined at that point that the volume was sufficient to be able to support a case manager in the emergency department. We called around the country and conducted an on-line search, looking for similar programs, but we found that there were no other emergency department case management programs. We collaborated and developed the CDH program from the ground up," Conway says.

A community resource

The case managers are more than just a resource for the hospital. They're a resource for the entire community, Lear adds.

"We frequently get calls from physician offices and people in the community who have questions or concerns about their health care. We do whatever we can to help them," says **Christine Plantier**, RN, BSN, emergency department case manager.

For instance, family members of elderly patients who want to remain independent have called the ED case managers with questions about what Medicare pays for or how to make arrangements for a community service.

"Our work goes beyond the doors of the emergency department. We link with the community-based physicians, and if we have identified a patient concern, we communicate with them to find a way to resolve it," Plantier says.

For instance, the case manager noted that there were noncompliant patients entering the emergency department with symptoms that indicated that their diabetes was out of control. The case managers collaborated with the patients' community endocrinologist nurse to help the patients manage their disease and obtain medication and supplies.

"Many of these patients are unable to comply because they either do not have insurance or the daily cost of their supplies is prohibitive. Without the appropriate early intervention, an admission to the hospital would be the end result," Plantier says.

When a patient comes into the ED, one of the case managers talks with the patient and family about advance directives, finds out their home

situation, initiates consults, and starts identifying their discharge needs.

"The emergency department is the primary entrance to the hospital. We look at our role as the gatekeeper. We have an opportunity to reduce the length of stay by starting the plan of care while the patient is still in the emergency department.

"We collaborate with the health care team to identify if an admission is required vs. a return to their home. When needed, we coordinate community services, such as home care, schedule appointments, and contact their physician's office," Plantier says.

ED holding bed unit

The hospital has created an ED holding bed unit (EDHU) for patients who are being admitted as inpatients or for observation when there is not a bed available on a monitored unit or the medical-surgical floor. The beds are not in a specific location but are designated as a holding bed on a patient-by-patient basis.

When a physician has written the orders to initiate admission and if a bed is not available, the case manager is alerted by monitoring the ED tracking board or receives communication from the charge nurse that there is a patient in the EDHU.

Depending on the patient's admission status, the ED case managers work with the ED nurses to start providing inpatient or observation care.

They initiate the initial case management assessment, identifying the patient's discharge needs and starting the preliminary discharge plan. The ED nurse contacts the case manager and social worker on the unit where the patient will be transferred and discusses the patient's clinical issues, psychosocial concerns if appropriate, and discharge needs, Plantier says.

"It's part of our mission to provide seamless and high-quality care for our patients and to promote a smooth transition to the nursing unit. It is also a great opportunity for us to explain the role of the case manager and to encourage the patient and family members to work with the case managers on the unit to continue to plan for their discharge," Plantier says.

The case managers and the social worker assigned to the ED often are asked to find subacute or long-term care placement for patients who don't meet admission requirements but who are no longer able to care for themselves or their loved ones at home.

"Sometimes a paramedic who transports an elderly patient to the hospital notices that the home is not well maintained or that the spouse may also be in poor health and won't be able to provide care after the patient is discharged," Lear says.

When an elderly patient is at risk, the case managers call Highland Valley Elder Services for a consultation.

Follow-up

When patients can't afford their prescriptions, the case managers tap into community and hospital resources to find a funding source. They may contact a community agency, call local physician offices to get samples, or negotiate a drug with a lower cost and the same clinical efficacy.

"In some cases, they'll call me to find out if we can pay for the medication out of our budget," Lear says.

If a patient has been to the ED several times for a nonemergent condition or is new to the area, the case manager helps him or her find a primary care physician.

The case manager makes follow-up calls after patients are discharged to from the emergency department to ensure that they have gone to their primary care physician for follow up, rather than returning to the emergency department.

*(For more information, contact **Jan Lear**, RN, CCM, at e-mail: jan_lear@cooley-dickinson.org.)* ■

(Continued from page 6)

The bed board staff are alerted when transportation is notified that a patient is ready for discharge. If the bed is needed immediately, the bed board staff notify housekeeping to clean the room immediately.

Spartanburg Regional Medical Center has created what it calls a Red Capacity Alert that notifies the staff that the hospital is approaching capacity.

When the hospital goes on Red Capacity Alert, it is announced over the hospital's intercom, alerting staff that the census has reached a critical level and that the likelihood of having to place patients in hall beds has increased tremendously, Hodge says.

Criteria for a Red Capacity Alert are:

- two patients holding in a holding area with no bed assignment for longer than an hour.
- two patients holding in a holding area with a bed assignment but who have not been moved to the bed within two hours.

Holding areas include the emergency department, recovery, and catheterization lab.

"We have guidelines for Yellow Capacity Alert when there is one patient in either situation, but we rarely use it. When we have one patient without a bed, we usually have two," she said.

As part of the initiative to improve patient throughput, the hospital has created eight hall beds on the medical-surgical and cardiac care floors. The beds are in an alcove near the nursing station with a curtain for privacy.

When the floor is totally full, patients who are stable can be moved into a hall bed.

"We have strict criteria about patients who can be in hall beds. They can't have nausea or vomiting or be on oxygen. They have to be mobile, because they have to walk down the hall to the bathroom. If we need a bed, we often move someone close to discharge to the hall bed," Hodge says.

Patients rarely stay in a hall bed more than a few hours. The exception has been during the influenza and pneumonia season when some patients have stayed in a hall bed overnight.

"Once we start using the hall beds, it heightens everybody's awareness and they work to ensure that the patients who are ready to go home can be discharged," Hodge says.

The hospital uses hall beds only on rare occasions when there is a critical need for beds.

"There were a lot of concerns about the hall bed system, and we looked at all of those before we set them up. Our main focus is the welfare of the patient, and having one nurse on the floor take care of one extra patient makes more sense than having the emergency center nurses take care of a lot of extra patients," she says

Hodge works 7:30 a.m. to 4 p.m. Monday through Friday, during the peak times for patient placement. When she's not in the hospital, the house supervisor takes over her job. Usually by the time Hodge leaves, all of the surgical patients have been placed and calls from physician offices have decreased.

Hodge works closely with the staff on the floors to maximize bed capacity, going to the units and walking the floors looking for beds that may be available soon. Part of her role is to help staff understand the need to get patients discharged as quickly as possible.

When you're on the floor, you see only your world. I can stand at the bed board and see the big picture. When the nurse manager or charge nurse feel like they're being pushed, they don't always like it but they do understand it," she says.

Hodge oversees the transfer of patients on the medical-surgical floor to the critical care unit.

"If a nurse notifies us that a patient needs a bed on the unit and the physician isn't there, I go to the floor and look at the patient to back up the nurse's call," she says.

Hodge mediates between floors in an effort to keep outliers from being moved from floor to floor.

"We have patients with long length of stay and nowhere to go. I try to keep from moving the patients with the long length of stay so they don't get lost in the flow," she says.

Patient throughput has a domino effect on everything the hospital does, Hodge points out.

"If we can't get patients out of recovery and into a room, we have to stop surgery, and that has a major effect on our revenue. That's happened only once since we started this system and only for half and hour," she says.

The hospital has not been on emergency department diversion for more than a year.

"Our administration makes a tremendous effort to avoid being on diversion whenever possible. We are the largest hospital in the area. Smaller hospitals need to feed patients to us for care that they can't provide. We have to be accessible for them," she says.

(For more information, contact:
- ***Stacey Hodge**, RN, at shodge@srhs.com.)* ■

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Sutter DM, CM programs strike balance for best patient outcomes

'What are primary needs?' is operative question

The successful integration of case management and disease management is the latest step in the ongoing evolution of the Sutter Health Sacramento Sierra Region Care Management Programs, says **Jan Van der Mei**, RN, the region's continuum case management director.

The program began more than a decade ago with a centralized nurse/social work model that was then called geriatric care coordination, later became chronic care coordination, and is now known simply as care coordination, Van der Mei notes.

The team is composed of registered nurses located within the physician office setting and medical social workers and health care coordinators who work with patients and their families to provide a comprehensive plan of care, she explains. The team facilitates ongoing contact with both the patient and the primary care physician to make sure all issues regarding the patient's health care are addressed as quickly and completely as possible, Van der Mei adds.

The first disease-specific program was added in 2002, she says, with the management of patients with heart failure, and expanded to include those with asthma (2003) and diabetes (2005).

The Care Management Programs support two physician groups and an independent physicians association (IPA), as well as five hospitals in the region, Van der Mei notes. "They're paid for by both the hospital and the physician groups, because all benefit."

Unlike with outside companies that monitor patients for physician groups or health plans, she says, "we have been asked to provide care management for our physicians as part of the medical group structure. We have access to the chart and can make medication adjustments using guideline-based protocols."

Rather than simply telling the physician that a patient is getting worse, she says, "we can really make a difference to the patient."

The challenge in the latest phase of the Sutter Health Care Management Programs, Van der Mei continues, was to "identify a way to work together to provide disease management and care coordination and not cause total confusion."

Part of that challenge, she says, was avoiding having three different case managers overseeing the care of a patient who, for example, had heart failure and diabetes along with psychosocial problems.

"It was a gradual process, as we identified patients with heart failure who were originally referred to the program because they had issues with transportation or caregiver support," Van der Mei says. "So when we started the heart failure program, we put the patient there and then figured out if that program or care coordination manages the patient. We did it by asking, 'What are the primary needs?'"

Van der Mei describes a typical scenario:

"Say Nora, a heart failure case manager, is making her scheduled monthly call to Mrs. Jones, and Mrs. Jones tells her, 'I don't know what my weight is, because I am having trouble reading the number on the scales, and by the way, I am

out of my medication and have signed up with Medicare Part D and don't know how to get my prescription filled.'

"Nora realizes she has a patient who is stable but who won't stay that way if she doesn't continue to monitor her weight and take her medications, but Nora is a heart failure case manager and has another appointment in 15 minutes."

After asking Mrs. Jones how she is doing and determining that she is not short of breath, Van der Mei continues, Nora asks the patient if it's OK if she calls the case manager who works with her physician. The case manager in the office, Linda, will then call Mrs. Jones and help her figure out what to do, Nora explains to the patient.

"After Linda calls," Van der Mei says, "she may do a home assessment or she may see Mrs. Jones when she comes in for a physician visit: Does she need an eye exam? Is the print too small?"

When Mrs. Jones' condition is stable, she adds, she will just get calls from Nora, the heart failure nurse. If the nurse identifies other problems, Van der Mei notes, or if the patient needs to be considered for hospice care, for example, Nora can make the referral or can talk to Linda about the issue, and Linda can talk to Dr. Smith.

Once Mrs. Jones is able to read the scale and handle her prescriptions, Van der Mei says, she goes back to Nora.

"So they collaborate," she says. "Who is the primary case manager is based on what is happening. If patients have comorbidities, like diabetes and heart failure, they have one of the case managers who is proficient in both diseases."

Case managers who handle more than one disease have a smaller caseload, she notes.

"The point is that the disease-specific case manager is really managing the disease, but because they have time constraints, they need support from the care coordination nurse with other issues," Van der Mei says. "You never deal just with the disease. There are always psychosocial issues."

As program staff worked to arrive at the appropriate care strategies, she says, they tried having patients with multiple needs remain in only one program, while closing them out of the other. In some instances, Van der Mei adds, the heart failure team would close out a case, turning the patient over to the care coordination team.

"If the patient got closed out from the heart failure program because so much else was going on," she notes, "then the heart failure was not man-

CE *questions*

1. Case managers should staff the emergency department 24 hours a day, seven days a week according to Toni Cesta, RN, FAAN, vice president, patient flow optimization for the North Shore-Long Island Jewish Health System.

A. True
B. False

2. CMS has announced its intention to tie outpatient reimbursement to quality measures in what calendar year?

A. 2007
B. 2008
C. 2009
D. 2010

3. A documentation enhancement project at North Mississippi Medical Center increased to case-mix index from 1.48 to what over a three-year period?

A. 1.92
B. 1.64
C. 1.78
D. 1.98

4. At Cooley Dickinson Hospital, emergency department case managers collaborated with community physicians' offices to obtain medication for noncompliant patients with what condition?

A. AIDS
B. Congestive heart failure
C. Diabetes
D. Asthma

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

CE instructions

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

aged as well, because care coordination is a more general team, not really focusing on the disease itself. So it worked out better to have the disease-specific program open and call in care coordination as needed."

One of the things Sutter Health did to enhance the quality and consistency of case management, Van der Mei says, was to identify 75 common syndromes or processes and list all the resources and interventions that might be used to address them.

"They were not necessarily diagnoses, but they could be," she explains. "We might identify all the things one would do if the patient had arthritis or was cognitively impaired, or had a fall. Intervention might be information on a support group or community resources."

Also included are processes patients should be familiar with, Van der Mei notes. "One of our goals for the program is to be sure to address advance care planning for all of our patients so they put into place an advance directive, so advance care planning is one of the categories.

"If the patient is cognitively impaired, the goal is to have a safe environment," she adds. "The interventions would include how to identify the degree of impairment and what tests the case manager should use to determine that. You would need safety measures, ways of indicating they might forget where they are.

"We've identified the potential interventions, so case managers should have everything they would consider doing for the patient in a list," Van der Mei says. "All of the identified interventions might not be indicated, but this enables a new case manager to be aware of the things they might consider for someone with the identified problems."

Sutter Care Management Programs have had success using specially trained support staff, rather than social workers or nurses, to do some of the monitoring calls, Van der Mei points out.

"When they identify problems," she adds, "the call is escalated to an RN, who does an assessment and determines what action to take. The support staff are able to do ongoing monitoring of stable patients in a fairly cost-effective way."

These employees are trained in-house, with an extensive orientation that includes scripting for patient calls and very clear parameters for when a nurse needs to be called, Van der Mei notes.

The combined programs managed more than 9,000 patients in 2006, with a total of 31 full-time equivalents (FTEs), she says. Some employees, particularly those in disease management, work in more than one program, Van der Mei adds.

Patient outcomes have been very positive, she says, and continue to improve. "Our outcomes include not only utilization measures but quality measures as well. We can clearly demonstrate that we've made a difference with our heart failure patients. There are fewer ED visits and fewer hospital visits compared to those who are not in the program, and our patients are on the appropriate drugs for their conditions."

It has always been true of patients in the care coordination program that they are healthier, have fewer visits to primary care physicians, and are able to remain in their own homes longer, Van der Mei adds. "Sometimes we have more home health visits and more durable medical equipment [DME] costs, because we make sure that patients have a cane, walker, or wheelchair."

JCAHO seal of approval

The Sutter Care Coordination Program, Sutter Heart Failure Telemanagement Program, and the Sutter Asthma Management Program received disease-specific care (DSC) certification in November 2003 and 2005 from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Van der Mei notes.

The Sutter Diabetes Management Program, which began in July 2005, will be up for certification in 2007, she adds.

"[Certification] is somewhat like accreditation, although not so complicated," Van der Mei explains. Requirements center around "how you deliver or facilitate care, that you use outcome measurements to make program improvements, and that your programs support and encourage self-management by patients."

There also are certain program management guidelines, Van der Mei says, including, for example, that the leadership roles in the program be clearly defined.

JCAHO's DSC certification is designed to evaluate disease management and chronic care services provided by health plans, disease management service companies, hospitals, and other care delivery settings, according to information on the agency's web site (www.jointcommission.org).

The evaluation and resulting certification decision is based on an assessment of:

1. compliance with consensus-based national standards;
2. effective use of established clinical practice

guidelines to manage and optimize care;

3. an organized approach to performance measurement and improvement activities.

Disease-specific care services that successfully demonstrate compliance in all three areas are awarded certification for a one-year period. After the first year, a one-year extension can be granted, contingent on the submission of an acceptable assessment by the organization of continued compliance with standards and performance measurement and improvement activities. ■

'Ideal Patient Day' gives heads-up on care

Schedule serves patient, not just staff

When Elmhurst Memorial Healthcare looked at improving patient throughput, one of the issues that surfaced had to do with housekeeping, which historically had deployed its work force in a way that did not serve the facility, says **Matthew J. Lambert III**, MD, MBA, FACS, FACHE, senior vice president, clinical operations. "We found that when we needed the most [housekeeping personnel], the fewest were there."

That problem, among others, was remedied with something called the "Ideal Patient Day."

"When a patient is discharged that is put in the computer, housekeeping is notified, and [staff] have a time frame in which they have to respond," he explains. "Rooms don't sit around empty."

However, the concept extends far beyond room turnaround, Lambert says.

"One of the things any physician or nurse will tell you is that in many hospitals, patients are basically diagnosed and treated at the convenience of the particular department that is doing whatever it's doing."

Patients can be resting, having lunch or seeing visitors, he continues, and someone will call and say, "We want to take Mrs. Jones to X-ray."

With the advent of the Ideal Patient Day, all patient activities must be scheduled in the computer, Lambert says.

"If physical therapy wants to see the patient, or radiology, they have to schedule a time, so [everyone involved] knows exactly what's going on with that patient for that day — within reason," he says. "Obviously there could be an emergency that would change that."

Know where your patients are

The new process has been very helpful, Lambert says. "Patients are getting to tests on time, tests are known about in advance. [Staff] no longer come up to the unit and say, 'Where is Mrs. Jones?' and hear, 'I don't know. She must be in X-ray.'"

Computerized screens much like those at airports, but not as large, show where the patient is and what is scheduled, he notes.

The three people who oversee the operations improvement program — Lambert, the chief financial officer, and the director of process redesign — spent a lot of time brainstorming solutions aimed at improving patient care, he says.

The Ideal Patient Day, for example, was an outgrowth of looking at how other industries do things, Lambert adds. "One of the things that piqued my interest was that if you have a package sent by Federal Express, you can get on the

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. ■

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Internet and follow that package.

"I started thinking about that and said, 'FedEx treats packages more like people, and we treat our people more like packages. Why don't we take a look and try to figure out how to do that kind of tracking?'"

Using an airport metaphor, he says, it's like having someone in the control tower — the nursing unit — who knows what's going on.

Despite the obvious benefits, implementing the Ideal Patient Day has not been easy, Lambert says. "It has created a lot of controversy in our organization.

"What it has done is it has taken away the autonomy of the department and the individual," he points out. "Physical therapy has been very resistant to scheduling appointments. [Physical therapists] like to show up when they want to show up. The clinical nutritionist is also a little unhappy."

The goal of the initiative is to put control back with the patient, Lambert says, and to get across the message to hospital staff that "it isn't just about you and your timeframe. We have to make sure the patient is not pulled away in the middle of lunch."

While people understand this conceptually, he adds, it's difficult for them to accept that they can't do what they want, when they want.

"When hospitals are facing this issue of capacity, admissions, discharges, getting people in and out, there are no quick fixes," Lambert emphasizes. "You have to go in and look at all departments."

And, he adds, "you have to be ready to get in deeply, measure everything. We break down the ED experience from the time the patient walks in the door to [discharge], with about eight different points and established goals for each of them. We measure not just the overall experience, but each individual segment."

The information that is tracked and presented on a regular basis includes the following:

- arrival to triage time;
- triage to room time;
- room to MD assessment time;
- time from when patient is placed in room until nurse sees the patient;
- admission order to bed assignment time;
- bed assignment to transportation order time;
- transportation order to depart from ED time.

"One of our major stumbling blocks was the transportation department — delays in getting a transporter," he says. "Now they all have time limits and expectations, and we deploy them to certain areas at certain times of the day."

Improving patient throughput and access to care requires an organizational understanding that there are no independent departments, Lambert points out. "If each department is seeking to maximize its own success, it's at the expense of others." ■