HOSPITAL CASE MANAGEMENT™

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

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IN THIS ISSUE

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MARCH 2007
VOL. 15, NO. 3 • (pages 33-48)

Experts: Lower caseloads when case managers take on more tasks

When the role is diluted, patient care coordination may suffer

It's happening all the time at hospitals across the nation. When a new initiative, like DRG assurance or clinical documentation improvement is developed, it's turned over to the case managers "because they're already in the charts."

As a result, many case managers already have more than they can handle, and because they're pressed for time to complete utilization reviews and discharge planning, their direct contact with patients may get short shrift, says **Toni Cesta**, RN, PhD, FAAN, vice president for patient flow optimization at the North Shore-Long Island Jewish Health System.

"Some directors don't push back when other jobs get loaded onto the case managers. They feel like taking on additional duties will add value to the department, but when it fails, it does the opposite," she says.

When someone has too many tasks to complete in a day, they can't do them all well, Cesta points out.

"There seems to be a myth that you can keep giving more and more tasks to case managers and they'll get it done, but when the role is so diluted, very little does get done well," she says.

The problem of increasing caseloads for case managers is compounded by the fact that many hospitals do not staff case management departments to allow for holidays or the inevitable employee absences, Cesta says.

"Hospitals never budget for nursing staff without having positions to cover sick days. In case management, when someone goes on vacation, is sick, or has jury duty, somebody else has to double their caseload to take care of the work," she adds.

Even when case management departments start out being staffed with good patient-case manager ratios, the department gets behind when some staff wind up with double assignments, Cesta says.

When Cesta talks to case managers across the country, most tell her that they're comfortable with their caseload as long as everyone is working and

they don't have to take on extra work.

"Many hospital administrators haven't caught up with the issue of case management caseloads. The department will always be running behind if staffing doesn't allow for vacations and sick time, but there are only a few places that budget for off time for staff," Cesta says.

When Cesta was a case management director, she budgeted for three additional case managers who floated around to the vacant positions.

"Even with three, there was never enough. We still ran with no coverage in some areas occasionally," she says.

Sarasota (FL) Memorial Hospital budgets for 1.5 full-time equivalent case management floating positions to cover vacations and absences, according to **Judy Milne**, RN, MSN, CPHQ, executive director for quality and patient safety.

The case management department converted some of its per-diem slots to the full-time float positions.

No magic formula

At Sarasota Memorial, clinical case managers who are registered nurses and psychosocial case managers who are social workers work together on the units with the psychosocial case managers assuming most of the responsibility for discharge planning.

"Before we had the clinical case manager float, the case managers were getting stretched more than the psychosocial case managers," Milne recalls.

There is no magic formula for assigning case manager caseloads, and it varies according to how the case management department is organized and the role function of case managers, Cesta adds.

The number of cases a case manager can handle depends on how the department is organized and the role function of case managers, she says.

"Case managers can do a lot of things if they have a small caseload. There has to be a balance in the number of functions and the right number of cases a case manager has to manage," she says. **(For a list of potential functions and how many a case manager can effectively handle, see related article on p. 36.)**

For instance, a pilot project that decreased the patient-case management ratio from 30-40 to 16-22 was so successful that Our Lady of the Lake Medical Center in Baton Rouge, LA, hired three additional case managers and reduced the caseload on the medical units. **(For details on their initiative, see related article on p. 36.)**

How patients are assigned to case managers also can affect the caseload. Unit-based case managers, physician-aligned case managers, and disease-based case managers all could potentially have very different caseloads, Cesta says.

For instance, St. Vincent's Medical Center in Jacksonville, FL, realigned its case management model to assign case managers by physician. The change lasted just one week.

"We had anticipated that case managers could

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

Subscriber Information

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

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

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This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This program has been approved by the American Association of Critical-Care Nurses (AACN) for 14 Contact Hours, Category O, file number 10852.

This activity has been approved by the Commission for Case Manager Certification for 18 clock hours.

This program was approved by the National Association of Social Workers (provider # 886399925) for 18 continuing education contact hours.

The target audience for **Hospital Case Management**™ is hospital-based case managers. This activity is valid 36 months from the date of publication.

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round with the physicians, get to know them, and have more impact on practice patterns. It worked well with orthopedists, neurologists, and other physicians whose patients were all on one unit. It didn't work well at all for internists and some specialty groups because the patients were on numerous units and the case managers lost a lot of time in transit," says **Jamie Zachary**, LCSW, the hospital's director of care management.

The case managers at St. Vincent's are responsible for utilization review with the help of clerical staff who get the requests from the insurance company and forward them to the case manager. The case manager conducts the review and sends it electronically to the clerical person, who sends it to the insurance company.

Documentation enhancement and core measures assurance is handled by the medical staff and the quality improvement department.

Caseload assignment

Case manager caseloads at St. Vincent's are based on the needs of the typical patients on the unit and the duties assigned to the care manager compared to the duties of the social worker. For instance, the hospital has a large cardiac program that serves many patients from South Georgia.

"These patients require a lot of intervention because they are from out of state. It is more difficult to set up someone from another state with home health, durable medical equipment, and other post-discharge services or post-acute placements," Zachary says.

Two case managers are assigned to the 30-bed cardiac unit. On other units, where the patients' needs are not as intense, caseloads typically run from 26 to 32.

"Caseload assignment depends on the acuity of the patients. We gather information electronically and know what services patients need on each unit," Zachary reports.

The hospital's case management software tracks the number of reviews, the type of reviews, the length of time each review type takes, and any discharge needs of the patient.

"If the patients on a particular unit typically need home health services or placements, we know that more time is needed and we need a lower patient-case manager ratio," Zachary says. The hospital has been using data from its case management software program to assign case managers since 2002.

"Before that, we made assignments based on our gut feelings and statistics that we kept manually," she says.

Originally, the hospital assigned only one case manager to the cardiac unit, but when the data showed a tremendous volume of patients and a lot of case manager tasks, the second case manager was assigned.

Smaller units at St. Vincent's have only one case manager who does the initial review within 24 hours of admissions, refers the patient internally for teaching, and coordinates any home health or durable medical equipment needs, working with the social worker assigned to that unit on complex cases.

On larger units, there are two case managers who conduct the assessment and social workers who handle the patient's discharge needs. The case managers are cross-trained to take care of the patient's needs for home health, durable medical equipment, or post-discharge placement if necessary.

Sarasota Memorial Hospital uses a dyad model for case management. Medical necessity review is the main emphasis of the clinical case managers.

"We emphasize medical necessity or utilization review for the clinical case managers. They handle less complex or clinically oriented discharge planning. The psychosocial case managers handle most of the discharge planning, particularly the complex cases," she says.

The case managers don't necessarily see every patient every day. They review all patients after admission and schedule a follow-up review at an appropriate interval, which may be every day in some cases.

The hospital's database tracks case manager caseloads and has a built-in complexity factor for discharge planning.

"We constantly look at our statistics to get a feel for the workload and complexity of patients the staff are dealing with," Milne says.

The hospital operates under a dyad model with one clinical case manager and one psychosocial case manager on almost every floor. One large medical unit has one clinical case manager and two psychosocial case managers. A cardiology unit has just the opposite — two clinical case managers and one psychosocial case manager.

"On the cardiac unit, discharge planning is not that complex, but throughput is a big issue, and the utilization review load is heavier than for many other patients. Even with two case managers, we sometimes feel stretched," she says. ■

Optimal caseloads depend on a variety of factors

Role function, model design, payer mix considered

The functions that case managers perform in your hospital can have a big effect on the caseload they can comfortably handle, says **Toni Cesta**, RN, PhD, FAAN, vice president for patient flow optimization at the North Shore-Long Island Jewish Health System.

"People often ask me what are the right numbers for a case management caseload, but it depends on so many other issues, such as the role function and how the department is organized. Case management directors have to create a balance between the number of functions a case manager handles and the number of patients he or she can manage and still do a good job," she says.

The number of patients for whom a case manager can coordinate care depends on many factors, including case management role function, the department's model design, payer mix, and intensity of services, Cesta points out.

Start by looking at the number of functions that case managers do or do not perform at your hospital, she suggests. These are likely to include:

- coordination and facilitation of care;
- utilization management;
- discharge planning;
- variance identification;
- quality management/core measures;
- documentation improvement.

Typically, if case managers on a medical/surgical unit are responsible for more than three of the functions, their caseload should not exceed 15, Cesta says. If they are responsible for three or fewer functions, they can handle a caseload of up to 20, she adds.

"In other clinical areas, like obstetrics, case managers could handle a higher number of cases," Cesta says.

However, there are other factors to take into consideration, such as the model design, including the relationship between nurse case managers and social workers, how many there are of each and who does what; weekend and evening coverage; coverage for vacations, holidays and sick time; and what areas the case managers cover in addition to the units, such as admitting and the emergency department.

Patients with high cost and high length of stay typically take up a lot of a case manager's time, and these case managers should have a smaller caseload, Cesta advises.

If you work at a small community hospital where complex patients are transferred to larger hospitals, your patients are likely to need lower intensity of service and case managers can handle more patients, Cesta says. On the other hand, tertiary care hospitals typically treat patients with more intense case management needs, and case managers should have lower caseloads, she adds.

Length of stay also affects the case manager load, Cesta point out.

"Some patients may have a short length of stay and need a quick turnaround on discharge planning. Patients with a longer length of stay may need more coordination of care and more complex discharge planning," she says.

Payer mix also can affect the workload a case manager handles, Cesta points out. Managed care patients typically need more utilization review and more calls to third-party payers. On the other hand, Medicare patients tend to have complex needs and comorbidities and need a lot of discharge planning. Medicaid patients are likely to have more psychosocial and financial issues than other patients.

Other factors to take into consideration include whether the case managers have clerical support staff to take care of paperwork and whether they can use a case management software program, rather than doing documentation and other paperwork by hand. ■

Smaller CM caseloads pay off for hospital

Costs are down, patient satisfaction up

Following a successful pilot project that decreased the patient-case manager ratio, Our Lady of the Lake Medical Center in Baton Rouge, LA, hired additional staff, reducing the caseload of case managers on the medical unit and giving them more time to interact with the patients and concentrate on discharge planning needs.

Before the initiative began, medical case managers carried a caseload of 30 to 40 patients. Now, the case managers on the medical unit have a caseload of between 16 and 22.

"In the past, the case managers were spending

90% of their time doing utilization review. Now we're finding that they spend 50% of their time at the patient bedside, communicating with the families about their concerns and determining how we can intervene to help," reports **Paige Hargrove**, RN, BSN, CCM, director of medical management.

The hospital conducted a pilot project for three weeks on two units — the medical unit and the surgical unit — in the fall of 2004 and began the lower patient-case manager ratio on the medical unit in January 2005.

"Our goal for the pilot project was to show the benefits of decreasing the patient/case manager ratio. In order to do so, we have to show that we could save money and increase patient satisfaction and nurse satisfaction," Hargrove says.

Data from the pilot project showed a 21% reduction in variable direct costs and a potential for saving $345,000 if the lower patient-case manager ratio was implemented on the medical units.

"We were able to show management that if they would give us three more case managers, it would pay for itself. Patient satisfaction and the reduction in variable costs were huge factors in getting the additional staff approved," Hargrove says.

Higher satisfaction

The hospital chose the medical unit for the lower case manager caseloads because those patients tend be sicker and need coordination of care while they are in the hospital and more post-discharge services. Case managers on other units still carry a caseload of up to 32 patients.

"The patients on the medical unit are typically elderly patients with a lot of issues in their lives. They have one of the highest lengths of stay and one of the highest morbidity rates," Hargrove says.

The initiative has resulted in a lower average variable direct cost per case and higher patient satisfaction.

Their success continued, even after Hurricane Katrina, when the average severity and average case mix index increased and the percentage of managed care cases decreased.

Now the case mix index still is up, the average severity still is up, the capacity still is up, and the indigent population is still large.

The hospital still has an unusually high number of indigent and self-pay cases, since not all Louisiana hospitals have reopened at full capacity following the hurricane.

"The indigent population creates a challenge because many still have no housing to go back to," she adds.

When the hospital ran data on the medical unit discharges from December 2005 to April 2006, compared to the four months directly preceding it, the hospital experienced a lower length of stay and a variable direct cost savings of $103,449, while the average severity and case mix index increased.

"In the time frame after Hurricane Katrina, we had an increase in length of stay from 4.69 to 5.51. From December 2005 to April 2006, it decreased to 5.30. Our length of stay on the medical unit is now 5.23, with a case mix index of 1.13 and an average severity of 2.18, which is its highest historically," she says.

At Our Lady of the Lake, case managers are unit based and are responsible for utilization review and discharge planning, along with the social workers on the unit.

The case managers on the medical unit see each patient on a daily basis and spend time getting to know them and building trust with the patients and family members.

"This arrangement allows the case managers to be more proactive than reactive. They have more time. If they have an order for a nursing home or hospice evaluation, they can make it happen on the same day, or at least make arrangements for transfer on the following day," Hargrove says.

The case managers in the medical unit are assigned by room number. They have a computer in the area where the physicians do their dictation. All three of them work with all the physicians and go on rounds with them whenever possible.

In the past, the case managers saw patients only when they had an order for a medical evaluation for discharge planning. Now they report any issues the patient has to the physician, smoothing the way for a timely and safe discharge.

"The case managers have earned the physician's trust. The physicians seek them out because they know they are an asset when it comes to providing better patient care," she says.

The new system has been a help with insurance certifications as well, Hargrove reports.

"With fewer patients, it's easier to give a review. By seeing the patient, the case managers can get a better picture of what is going on with the patient. Just looking at the chart doesn't always give a complete idea," she says.

The goal of the project was for the case managers to round with the physician and to attend the shift handoff with the nurses, added Hargrove, who was the case manager for the pilot project.

"I rounded on every patient every day. They had my card and knew how to reach me if they needed something," Hargrove says.

During the pilot project, the hospital had only one insurance denial among the patients in the project.

Having a lower caseload enabled Hargrove to keep up with the patients and alert physicians and the nursing staff to issues they might not otherwise know.

"I was in the chart the whole day, and I knew what was going on. The bedside nurse doesn't have time to read the whole chart. At the shift handoff, I chimed in if things were going on with the patient that the nurses were not aware of," she says.

Measures of success

Hargrove found it was useful to attend rounds with the physicians because she could be a back-up for what the physician told the patient. For instance, one patient complained that she could not sleep and the physician said he would write an order for a sleeping pill but did not enter it in the chart. Hargrove reminded him, saving time for the bedside nurse who otherwise would have had to call for the order.

"Having the case manager attend rounds improved communication between the staff and continuity of care," she says.

Before the project began, the case managers met with the performance improvement team and came up with a plan and questions that would determine the effectiveness of lower case manager-to-patient ratios. The team picked two different units for a pilot project during two different times.

The team developed short questionnaires to determine satisfaction. Respondents were asked to rank their satisfaction from 1 to 5.

The nurse satisfaction survey had only two items: I am aware of my plan of care. I am satisfied with my work day. The nurses were asked to rank their satisfaction from 1 to 5.

The physician questionnaire had four questions: Was information, such as test results, available in the chart in a timely manner? Was the information accurate? Were the nurses available when you needed them? Were the orders carried out in a timely fashion?

During the pilot project, the hospital used portions of its regular patient satisfaction surveys as another measure of success.

The surgical unit experienced a mean score of 94.4 for help in arranging home services and a mean score of 80.8 for speed in the discharge process during the pilot.

Data for the medical unit indicated a mean score of 93.6 for the discharge process and a mean score of 100 for arranging home services during the pilot project.

The length of stay was reduced by 9.5% on the medical unit and by 4.6% on the surgical unit. ■

Team recovers $2 million per year in denied claims

One care manager is responsible for appeals

Having a dedicated team responsible for following up on denied claims has generated an average of $2 million or more in recovered revenue for United Health Service Hospital every year since the first full year of the initiative in 2001.

"We knew that the organization was leaving a lot of money on the table. In 2000, we organized a team to look at why we were getting denials and what measures we could put into place to make sure we get the reimbursement we are due," says **Pat Chamberlin**, RN, CCM, CCUR, care manager of the dedicated recovery unit at the Johnson City, NY, hospital.

The case management department has dedicated one care manager to handling the appeals of all denials that do not involve coding or billing problems. Those denials are handled by their respective departments.

"Having a dedicated case manager with responsibility for appeals has been a positive step for the organization. Now the finance department and the health information department know one person to contact when they have concerns, says **Michele Gordon**, RN, BSN, manager of the care management department

Payer groups like the system because they have one person with whom to correspond, she adds.

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CRITICAL PATH NETWORK™

Hospitalwide program results in top core measures scores

Case managers track compliance in ED, on units

Thanks to an intensive program monitoring the core measures requirements throughout the hospital, Methodist Medical Center has been ranked among the top three hospitals in the state of Tennessee for compliance with the core measures for two years in a row.

The Oak Ridge, TN, hospital received the ranking from Health Insights, a nonprofit Medicare Quality Improvement Organization, based on data from the Centers for Medicare & Medicaid Services (CMS).

Case managers in the emergency department and on the units monitor the core measures concurrently, working with the nursing staff and physicians to make sure the recommended care is followed and documented, says **Coletta Manning**, RN, MHA, CPHQ, director of clinical effectiveness and quality improvement.

The hospital began its core measures initiative with an extensive education program for physicians.

"We showed them what the core measures are, why they are important, and how we were going to be judged on our compliance. We talked about pay for performance and how much it will mean to the facility if we're in the top 10%," she says.

"We tried not to focus on the monetary incentive but rather show the physicians that core measures compliance is the right thing to do for the patient," she adds.

The case managers track the physicians' records when it comes to the core measures, documenting each time a core measure is missed.

In some instances, the case managers shadowed physicians, pointing out when the core measures were called for and occasions when the physicians needed to document that core measures had been implemented.

For the first six months after CMS began tracking the core measures, the case management department collected compliance data and gave them individually to each physician and nurse, to provide feedback for improvement," Manning reports.

After six months, the hospital began sending letters to the physicians, listing their failure to comply with the core measures and educating them on the importance of compliance. The letter becomes part of their employee files and can be used as part of the reappointment process.

Manning compiles the data and gives reports to the physicians, nursing, and the rest of the medical staff on a quarterly basis. The hospital also shares the information with companies with which it contracts for services.

Physicians in the emergency department who don't miss a core measure each quarter receive recognition and a small reward. In one recent quarter, three emergency department physicians had no deficiencies in meeting core measures. There also is a laminated guide in each chart for easy reference.

The case management staff posts reminders of the core measures goals in requirements in the emergency department, staff break rooms, and nursing stations.

In addition, the nursing department has a dashboard on each floor, showing how the unit is doing on each of the core measures appropriate for their patients.

When a core measure is missed, the case manager fills out a form that includes information on what was missed and why the particular treatment or procedure is important.

She gives the form to the manager, who passes it on to the staff person who failed to institute the core measure. The staff person has to respond to the manager as to why the core measure was missed.

The responses are discussed in the quarterly nurse quality meeting attended by the case managers and nurse managers.

"We look at the reasons that people aren't ensuring that the core measures were met and see if there are any process issues we can resolve," Manning says.

For instance, the nursing staff weren't always giving flu shots to eligible pneumonia patients.

"We changed our procedure so we don't need a physician order to give the flu shots. We developed a form with the criteria for pneumonia vaccination on one side and the criteria for influenza vaccination on the other. If the patient meets the criteria, he or she gets the shot," she says.

The case management department has standing time on the agenda at nursing staff meetings to talk about the core measures.

"Nobody wants to fail to give the patient the recommended care. We try to determine why they forget or what other barriers there are to care and determine if it's something we can fix," Manning says.

In addition to the core measures for pneumonia and acute myocardial infarction, the entire emergency department staff are working on getting patients with an acute MI who meet appropriate criteria to the catheterization lab in 90 minutes.

The team includes cardiologists, representatives from the catheterization laboratory, the emergency department manager, the emergency department case managers, and the case manager for cardiology.

Every month, the team studies the medical records of every patient who did not get to the catheterization lab within the 90-minute window.

"We look at every single patient to see what the holdup has been. We also look at those who did get there in 90 minutes to see what we did right," Manning says.

The staff found that the biggest challenge is getting the catheterization lab crew back to the hospital when it's after hours.

"Some of our cardiologists are not interventional cardiologists, and if one of them happens to be on call, it's also a challenge," Manning says.

Methodist Medical Center had already been tracking many of the core measures on the clinical pathways implemented in the early 1990s. The hospital has moved to an electronic version of the care plans, which include standardized order sets. The hospital has specific pathways for certain procedures and diagnoses.

"The core measures were not really new to us. Many had been on our Care Trax since 1992, and we already had physician buy-in for the practices. We have put a lot of things in play to make it better, but we don't have 100% compliance. We're getting there, but until we implement the core measures 100% of the time on every eligible patient, we won't be satisfied," Manning says. ■

CMs at hospitalist meetings improves care

Improved communication helps free up beds sooner

When a representative from the case management department began attending the daily meeting of a large hospitalist group at St. Vincent's Medical Center, the Jacksonville, FL, hospital began to see an improvement in patient throughput almost immediately.

"By going to the meetings, I can be a conduit of information between the case managers on the unit and the hospitalists. The improved communication helps us with capacity issues and to free up rooms for patients waiting in the emergency department," says **Jamie Zachary**, LCSW, the hospital's director of care management.

Two large hospitalist groups admit about 60% of all patients to St. Vincent's Medical Center. All of the patients treated by the hospitalists come from the emergency department. The hospital rotates referrals from the emergency department between the two groups.

"One group of the two groups of hospitalists meets only monthly, so we don't have that forum to be involved. The other group meets every day," Zachary says.

The hospital began the initiative six months ago when one of the hospitalists commented that they could operate more efficiently and effectively if they had one person they could contact every day about discharge plans and other issues.

Zachary started going to their daily meetings

the next day.

The hospitalist group meets for 30 minutes every day. Either Zachary or the manager joins the meeting for the last 15 minutes.

"It has created much more effective and timely patient care. Increased communication has been the big factor. It's certainly worth 10 or 15 minutes of our time," she says.

The case managers on the unit leave a voice mail message about any issues or questions they want Zachary to discuss with the physicians.

"We get the information they need and get it back to them as soon as the meeting is over. It's been very effective in getting the information the case managers need back to them in a timely manner," she says.

By attending the meetings, Zachary gets information on patients who are likely to be discharged that day and passes it on to the case managers before the physicians get to the unit for rounds.

"This ensures that all of the plans are in place for patients being discharged and that there is nothing holding up their discharge," she says.

When a physician is planning rounds later in the day, Zachary takes verbal discharge orders for his or her patients.

"Sometimes the physicians don't go to the unit until after noon. With the verbal orders, we can have everything in place, including the patient's transportation, by the time the physician arrives on the unit," she says.

The hospitalist group employs nocturnists who sometimes change the treatment plan overnight.

"Sometimes something has happened with the patient overnight and the nocturnist has made a change in the plan for the patient. I can alert the case manager to the change in the treatment plan first thing in the morning," she says.

When Zachary looked at length-of-stay data on the three units where the hospitalists have a high volume, she found that the length of stay had dropped.

"The length of stay wasn't high to begin with, but the data showed that this hospitalist group practices more efficiently than the independent physicians and that they have reduced their length of stay," she says.

The program started just six months ago, and extensive data is not yet available.

"One of the indicators we're hoping to affect is the number of patients who are discharged before 2 p.m. One of our goals is to move the discharge time up and get people out sooner. We also have the opportunity to communicate to the physicians how many patients are waiting in the emergency department for beds and what type of beds are needed," she says.

Zachary meets with the other hospitalist group once a month to discuss hospital processes, protocols, and administrative issues. She presents information on issues such as length of stay and resource utilization. ■

Team improves throughput, avoids ED diversions

Initiative includes reducing wait for beds

When Sarasota (FL) Memorial Hospital began experiencing a big spike in emergency department diversion, the hospital created a multidisciplinary committee to determine why the diversion was occurring.

The hospital had experienced several diversions in the past until 2004 when the hospital was on diversion 26 times between June and November.

"It wasn't even our peak season. The staffing looked good. The length of stay was good, but we were not able to get the patient flow we needed so our emergency department wasn't backed up," says **Judy Milne**, RN, MSN, CPHQ, executive director for quality and patient safety.

The mission of the team was to eliminate diversions and to reduce the number of patients waiting for a bed for more than two hours. At that time, 42% of patients were waiting more than two hours to occupy a bed.

At Sarasota Memorial, case managers are responsible for assessing for medical necessity and discharge planning, coordinating with nursing to get the patients ready for discharge as early in the day as possible.

"This initiative reinforced the importance of the case managers' role to screen the patients to avoid inappropriate admissions and to optimize our bed use by getting patients to the right place. We put an emphasis on unnecessary days and try to avoid those by staying on top of the discharge plan," she says.

The team looked for the biggest delays in finding inpatient beds and determined that more surgical patients were waiting longer for beds than patients who were medical admissions or who

came through the emergency department.

Statistics showed that 39% of all delays of more than two hours occurred on the surgical nursing units.

One of the hospital's inpatient nursing units was a mixed unit that also included recovery beds for short-stay surgical patients, most of whom were in the hospital for gynecological procedures but who couldn't go to the Phase 2 recovery unit because they needed a bed, not a recliner.

When a nurse has patients who are staying only a few hours on the unit and those who have stays of a day or longer, the workflow is affected, Milne says.

"The longer length of stays of many patients on the unit made it hard for the nurses to focus on the rapid throughput of the short-stay patients," she says.

The team created an outpatient post-surgery recovery area with 14 to 16 beds available Monday morning to Saturday morning for short-stay surgical patients who aren't appropriate for the Phase 2 recovery unit.

"It worked beautifully and seems to have minimized the diversion issue," Milne says.

The team studied the pattern of patient arrivals and departures and determined that the hospital often was above capacity in the middle of the day.

"The pattern of arrival was not matching the patterns of discharge. The peak time is around noon to 4 p.m. or 5 p.m.," she says.

Direct admissions typically peak in the late morning after physician office hours and after 5 p.m. to 6 p.m. The emergency department admissions are steady during most of the day but get heavier in the latter part of the day and into the evening and night.

"We start looking for beds for our surgical patients at 10 a.m. or 11 a.m., but most patients aren't being discharged that soon. We did a lot of work around patient placement processes to free up more beds earlier in the day," she says.

The hospital began posting the percentage of patients waiting more than two hours for a bed, broken down by nursing unit. The team looked at roadblocks to bed turnover, including how quickly housekeeping got to the rooms and patient transportation issues.

The team focused on the ancillary departments, such as radiology, laboratory, housekeeping, and transportation, to determine where some of the roadblocks were occurring and what they needed to do to facilitate patient throughput.

"We also looked at the nursing units to determine how quickly they could discharge patients and make beds available," she says.

When the project began, nurses who were discharging patients had to enter the information twice, once in the electronic medical record and once in the admission/discharge/transfer software, which alerts the bed board team in the case management department that a patient is pending discharge or transfer.

If the nurse forgot to input the information into the admission/discharge/transfer software, the bed board staff didn't know what was taking place.

The team worked with the hospital's electronic medical record software vendor so that the nurse could enter the patient disposition in the software and it would send a message to the bed board staff.

"We eliminated a step so that the nurses didn't have to go into another software program. They could automatically notify the bed board through the electronic medical record. We now get pending transfers and discharges in real time, and it helps us anticipate beds and place patients in a more timely fashion," she says.

The case managers on the unit are in constant contact with patient placement about the status on discharging patients.

"All these tiny details make patient throughput click. It all fits together," she says.

The team's next step is to focus on scheduled discharges and to anticipate the peak times for arrivals and departures.

"Our goal is to get more patients discharged earlier in the day in order to increase capacity," she says. ■

(Continued from page 38)

In the past, case managers were responsible for appealing their own specific denials in addition to their other duties, says Chamberlin, who has been the care manager of the dedicated recovery unit since 2006. The position was created in 2003.

The system has allowed the case management department to create summaries of denial information showing the staff areas where the hospital is at risk for denials and showing various departments practices that could be modified to prevent denials, Gordon says.

"When each case manager was tracking his or her own denials, we didn't have the ability to compile information in one place," Gordon says.

The hospital had 403 denials, totaling $3.6 million in 2006. The dedicated recovery team recovered $2.15 million and has more than $900,000 in appealed claims still pending.

The hospital has chosen not to appeal some denials; others have been appealed and lost.

How the system works

The dedicated recovery unit was created by a team that included representatives from the care management department, the finance department, medical records, coding, nursing, registration, insurance verification, and health information management.

As a result, the coding unit developed its own initiative to improve documentation concurrently. The finance department looked at ways to improve the accuracy of billing. The case management department dedicated a case manager to appealing all other denials to one case manager.

The dedicated recovery unit was launched in the last few months of 2000 and, that year alone, recovered $500,000 in denied claims.

Here's how the system works: When the finance department gets a denial that doesn't involve coding or billing, it sends the information to Chamberlin to determine if there are grounds for appeal.

She evaluates the new denials sent for review and sends the finance department an opinion on what the response should be. She initiates the steps in the appeals process and follows up on outstanding appeals.

The primary issues that Chamberlin deals with are admission status, lack of precertification or preauthorization, and medical necessity.

When Chamberlin gets a denial, she pulls the medical record and compares it with the reason the insurance company gave for issuing the denial.

"I look to justify the hospital records. If I feel they are denying us unfairly or incorrectly, I review the InterQual criteria and the medical record and draft a letter stating our side of the issue," she says.

For instance, if the insurance company denied the claim because of lack of precertification, Chamberlin checks the records to see if the precertification was documented. If the admission was an emergency, Chamberlin has grounds to challenge the precertification requirement.

"If they deny the claim because the patient met outpatient criteria and we billed the care as inpatient care, I look at the medical record to see if the patient did meet inpatient criteria. If the insurance company was correct, I make sure the procedure is billed as an outpatient procedure," she says.

Chamberlin is responsible for denied claims issued by commercial insurers, Medicare and Medicaid managed care plans.

"We have an increasing population of managed Medicare and managed Medicaid payers. I manage denials from those as well," she says.

If the hospital appeals and the insurance company upholds its decision, Chamberlin appeals on a higher level.

"If we think that we are correct, we can challenge it further and provide any justification needed, including involving the physician in some cases," she says.

If the insurance company's reason for denial is unclear, Chamberlin contacts them for clarification.

When she spots a pattern in denials, Chamberlin works with the staff to make sure that the hospital meets the insurer's criteria in the future.

"We were seeing a pattern in denial for patients who came to the emergency department for a short-stay surgical procedure. The insurer wanted to pay for outpatient treatment and we had placed them in inpatient status. I clarified with the payer their definition of inpatient and outpatient criteria and made sure the staff knew the difference," she explains.

Once the appeal is initiated, Chamberlin keeps track of where it is and contacts the insurance company if it doesn't issue a response in a timely manner.

The team has streamlined the filing system, creating separate files for open appeals, pending appeals, those waiting for more information, appeals that are at the second or third level, and closed appeals. Much of Chamberlin's work is

done on the computer, but she also makes hard copies to back up all of the information.

When patients are from out of the area and become sick or are injured while traveling in the region, Chamberlin researches the insurers' requirements and finds out where to send the appeal.

"We're familiar with our local insurer's requirements for precertification and pre-authorization, but out-of-network insurers or those who are out of state require more investigation," she says.

Chamberlin attends monthly meetings with the finance department during which local payers give updates on their products and changes on admission or referral requirements.

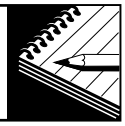
"We stay on top of the payers so we can alert staff of changes in requirements so we can avoid denials," she says.

She acts as a resource for the staff, advising them when they have questions about documentation that may result in a denial.

"The staff is very good at working with me, and if they get any indication that we may get a denial, they give me a heads-up so I am aware of it," she says.

The hospital liaison for one of the hospital's largest payers conducts concurrent reviews on site and talks to Chamberlin on a daily basis about anything that may be a denial. ■

GUEST COLUMN



How to maximize CM staff retention

Explore reasons for staff turnover

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

Finding, motivating, and retaining qualified case managers and support staff can be a challenge. The reasons for employee turnover are many — low unemployment, a more mobile work force, promises of higher wage and benefit levels, and feelings of not being recognized or appreciated. While managers often cannot control the monetary issues that cause staff to seek employment elsewhere, there are many factors that managers do have power over. Staff turnover rates can be decreased through proper recognition, rewards, and motivation.

Do staff feel a part of what's going on at work? Employees want to have a say in what work will be done, the sequence of the work, and how it will be accomplished. They want input into changes in their work environment, scheduling, and perhaps even the hiring of new employees. When staff are not allowed the opportunity to get involved, they become alienated toward management and the organization. This is a common reason case managers seek employment somewhere else. Having a meaningful role on the job and being included in work management decisions is particularly important to the better employees. These are the employees who are often eager to participant in department decision

Figure 1: Questions for Departing Employees

- What are the primary reasons why you decided to leave your position?
- What did you like most about your job? Least?
- How did you feel about working with other staff in the case management department?
- In what way did your job fail to meet your career objectives?
- What part of your job did you find most frustrating?
- How would you rate the management support you received?
- If you could have made any job changes, what would they have been?
- Do you feel you were given ample opportunities for professional and personal growth?
- How would you rate the overall working conditions?
- Have you already accepted another job? If so, in what areas do you find your new job more attractive?
- What could have been done to make your job more rewarding?
- What skills do you most enjoy using and why? Were you able to use them in your position here?
- What made you unhappy about your job? In what ways do you think a different job would be an improvement?
- Did you feel your opportunities were limited here? If so, what could we have done to help you advance your career goals?

making — and these are the employees you'll miss the most when they decide to go to work for another facility.

Soliciting staff member opinions does not necessarily mean that the advice or preference must be followed. The ultimate decisions still rest with the manager. However, by asking for input, the manager is reinforcing the value of employee viewpoints and the importance of taking those opinions into consideration.

Does everyone in the case management department feel appreciated? Are they periodically recognized for the work they do? Often staff are recognized only when they do something extraordinary that gets attention. It seems people are only noticed when they do something exceptionally good or exceptionally bad. Yet, the performance of routine work is vital to departmental operations — if it were not done, things would not go smoothly.

The most valuable staff in the department are those that come in every day, don't bother anyone, and get their work done in a reliable, routine manner. Every once in a while, the manager should take time out to thank those people who usually don't get thanked. Show some appreciation for the routine work done by employees in addition to the more exceptional accomplishments.

Do staff receive detailed performance feedback? Good employees want to know specifically how they are doing and how they can improve. When talking with staff about their performance, include explicit examples to illustrate both good and unacceptable performance. When staff have a better understanding of what is needed to fulfill their job responsibilities, they can make definitive modifications to meet expectations. Simply saying, "Gee, you're doing great" doesn't provide people with the information they need to be successful in their job. Staff should understand what tasks are to be done, how they are to be accomplished, and when work is to be finished.

Do people have fun at work? The job of case management must be taken seriously, and everyone has a significant amount of work to do. However, staff also should have some fun while they work. People working in an environment that promotes camaraderie will be more relaxed and happy — which translates into higher productivity. Celebrate birthdays, promotions, and other special events with short parties. The celebrations do not have to be long at all; just a short period of fun together can go a long way toward building teamwork and positive feelings about work. You can't take stress out of the job of case management, but

CE *questions*

9. How many full-time equivalent floating positions does the case management department at Sarasota Memorial Hospital have?
A. 1.5
B. 2.5
C. 2
D. 3

10. Lowering caseloads in a pilot project at Our Lady of the Lake Medical Center resulted in what percentage reduction in variable direct costs?
A. 15%
B. 17%
C. 21%
D. 25%

11. How much in 2006 denied claims has the dedicated recovery team recovered for United Health Service Hospital?
A. $2 million
B. $2.15 million
C. $2.46 million
D. $3 million

12. What percentage of patients do hospitalists admit at St. Vincent's Medical Center in Jacksonville, FL?
A. 60%
B. 65%
C. 40%
D. 50%

Answer key: 9. A; 10. C; 11. B; 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 **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. ■

you can reduce the cognitive overload on staff by providing time for some relaxation.

Do people have the tools they need to get their jobs done? Waiting in line to use a photocopy machine can inhibit productivity and create staff dissatisfaction. Not having the right information to make timely discharge planning or utilization decisions can be costly in terms of staff time and stress. People in the case management department want to do a good job, and it is important to give them what they need to achieve peak performance. If work is made too difficult because of inadequate resources, staff soon may look for employment elsewhere.

Are some tasks unnecessary? Rules, regulations, and procedures that people view as unnecessary can be frustrating. Take a good look at all aspects of the case management process to identify anything that might call for extra paperwork, needless steps, superfluous approvals, or similar nuisances. Whenever possible, slash red tape and eliminate burdensome requirements. Do whatever is needed to make it easier for case managers to get things done. Good employees can quickly become frustrated by nonsensical or redundant tasks.

Is professional and personal development a priority? Employees should be encouraged to participate in ongoing education and training that updates and expands their skill level and personal development. Don't limit this encouragement to the clinical staff in the case management department. Clerical and technical support staff, also valuable employees, can benefit from continuing their education and training. The department may offer a stronger degree of financial assistance for job-related courses than it does for courses that don't relate directly to the employee's work. Be careful about being too focused, however. While employees are learning about subjects that are not specifically job-related, they also are strengthening their self-discipline and self-esteem.

Unnecessary turnover is expensive in terms of recruitment costs, service inefficiencies, and lower staff morale. For this reason, understanding why employees leave is important.

One way to explore the issue is to ask departing employees specific questions about ways in which the department could improve **(see Figure 1, p. 44)**. These questions could be part of an informal exit interview with the manager or be incorporated into a post-exit written survey. To reduce defensiveness, be sure the employee knows that anything they say will not be held against them or influence references. The employee's answers may not tell the whole story, but they can be useful for formulating strategies that can help prevent other employees from leaving the department.

Staff retention certainly is a high priority for the case management department, and by responding to the needs to employees, turnover can be reduced. Employees need an environment where they are respected as valuable members of the department and the health care team. They must be recognized for their accomplishments and given the opportunity to do their best every day. Employees need to understand how they are making a difference and are encouraged to grow both professionally and personally. A case management department lacking in these qualities often has high staff turnover as well as stressed-out employees who, for whatever reason, choose to stay working in that department. ■

AMBULATORY CARE
QUARTERLY

Shared governance keeps ED nurses, patients happy

Ranking in 95th percentile or higher for 10 years

Garnering patient satisfaction scores in the 95th percentile is impressive, but doing it for 10 consecutive years really makes people sit up and take notice.

That's exactly what's happened with the ED at Southwestern Vermont Medical Center (SVMC) in Bennington. The department is one of 12 winners of the newly created Summit Awards, presented by Press Ganey Associates of South Bend, IN, to departments rated in the top 5% of the nation in terms of satisfaction for the last three years. A total of 925 EDs were surveyed.

As a matter of fact, says **Sheila Ritoch**, RN, director of critical care services, the department has been in the 95th percentile since 1997 and, in 2000, it hit the 99th percentile. It ranked in the 98th percentile for 2006. She gives much of the credit to the shared governance model of nursing in the department. "The nursing staff have a say over what our practices are," Ritoch explains. "For example, they sit in on all interviews for potential candidates who have applied for positions." Southwestern Vermont is a magnet hospital,

which is a gold seal of approval given by the American Nurses Association to facilities that pass a rigorous survey.

When you are a magnet hospital, one benefit is that you are able to attract and keep the best nurses, says **Daniel Perregaux**, MD, the ED medical director.

During the interview process, Ritoch and the nursing staff evaluate not only nursing skills, but attitude and communication skills. "We try to focus on someone who has a good sense of humor and a positive attitude," she says.

Nurses also sit on the policy and procedures committee, Ritoch says. "Any changes that are coming down, any equipment buying, anything that is going to impact their practice, we discuss and talk about the best way to implement it," she says.

How does this translate into improved patient satisfaction? "When nurses feel they are heard and have control over their practice, it gives you a satisfied nurse with a positive attitude," Ritoch explains. "There isn't a single nurse here who does not have their focus on the patient."

The nurses in the ED realize that patient perception is reality, says Ritoch. "If the patient feels unhappy, they know there's something we could have done better," she says.

Making it better

When patients do express dissatisfaction, the nursing staff have the ability to give them a coupon they can use in the hospital gift shop. They often go beyond the call of duty to make an unhappy patient happy again.

"One time, a little boy broke his arm, and the paramedics had to cut his 'Hard Rock Café' T-shirt off," Ritoch recalls. "He was heartbroken, so the staff took it upon themselves to go out and get him a new T-shirt." On other occasions, she says, they have purchased coupons for groceries.

When complaints reach her desk, Ritoch sends a note to the nurse to discuss the matter. "Our approach is: What can we do to change perception the next time?" she says.

Another key to higher satisfaction levels has been a change in the staffing patterns, which came in the wake of studies on turnaround time to discharge, she says. "We looked at what our busiest times were and tried to adjust staffing between 10 a.m. and 10 p.m.," she says. "We start with one number of RNs at 6 o'clock, add more at 8, and then at 10, so we always have the right amount for the quantity of patients."

The staffing model for physicians and physician assistants (PAs) has changed in recent years as well, says Perregaux. "One local hospital closed, and the volume came to us; we responded by increasing our PA staffing over the years," he reports. "This way, we can see patients quickly and make sure they get the care they need."

Ritoch says a remodeling of the ED also has contributed to patient satisfaction. "We installed TVs and phones in all the rooms," she says.

New protocols help

Perregaux is convinced that his active CME program and updated protocols also benefit patient satisfaction.

"We have a very aggressive program for maintaining airway certification. We've started work on triage protocols to facilitate care for pneumonia and sepsis, and we have had long-standing stroke and cardiac care protocols," he says. "This

CE objectives

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

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

COMING IN FUTURE MONTHS

- Which disciplines can handle utilization review?
- How case managers can be involved in disaster planning
- How to keep tabs on the transfer DRGs
- Proving the worth of your case management department

enables us to rapidly initiate care, and even if the patient is really ill and unaware, the family sees what we are doing and takes notice."

Administrative support is critical, he adds. "I've worked at various facilities across the country, and without reservation, this facility's administrative interaction with the medical side is remarkable and dramatic," he says. "We feel our opinions and observations are being heard, and that extends very directly to patient care." ■