HOSPITAL CASE MANAGEMENT™

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

AHC Media LLC

IN THIS ISSUE

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MAY 2007
VOL. 15, NO. 5 • (pages 65-80)

For case managers, business isn't a dirty word; it's just part of the job

Case managers need to balance patient care, finances

As a case manager, your job involves being an advocate for your patients as well as keeping your hospital's best interests in mind, and that means being informed about the business end of health care.

"Case managers have a blended role. They are patient advocates and hospital advocates, as well, and unlike nurses, case managers need to understand the financial aspects of patient care," says **Beverly Cunningham**, RN, MS, vice president of clinical performance improvement at Medical City Dallas Hospital.

Case managers need to have balance between what is going on clinically with the patient and the financial ramifications of the particular case, adds **Frank Danza**, CPA, vice president of revenue cycle management for Northshore Jewish Health System.

"It is important that we as case managers understand that our job is not just utilization review and planning for treatment and discharges. Part of that plan has to include the financial piece," adds **B.K. Kizziar**, RN, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

Case managers don't always get involved in the financial side of care or patients' reimbursement, but they should, she adds.

Understanding the business side of patient care means having a basic knowledge of the contracts your hospital has with payers, Medicare and Medicaid requirements, the services that each will and will not pay for, and the financial impact of additional time in the hospital for both the patient and the hospital, Danza says.

Insurance companies are scrutinizing claims more intensely than ever. This requires case managers to be more involved than ever before to make sure insurers' requirements are being met, Cunningham points out.

And, to be a true patient advocate, which is the No. 1 duty of case

managers, case managers need to know what kind of health care benefits the patient has, what is covered in and out of the hospital, and any kind of limitations, such as maximum annual coverage or maximum number of ancillary benefits, Kizziar says. **(For more on how a patient's benefits can affect the treatment plan, see related article on p. 68.)**

Keeping up with the hospital's contracts can be confusing. Northshore Jewish Health System has contracts with 30 different payers, many of which have multiple insurance products. "They pay under different methods and some have outlier provisions and some don't. Some pay a per diem rate and others pay a case rate," Danza says.

Case managers' financial responsibility to their patients begins with providing whatever information the patient's insurance company needs about medical necessity and coordination of care, Cunningham says. "If the case manager fails to call the insurance company in a timely manner, the company may issue a technical denial," she says.

What you need to know

Know the provisions of your hospital's contracts with the payer and understand what they mean. Know the denial process and what will cause a denial.

"Case management directors should educate their staff about insurance contract components and have a working relationship with the person doing the contracting, usually the vice president of managed care," Cunningham says.

Case managers should find out what kind of information the major payers are looking for and at what intervals and understand the criteria used by the insurance company. More payers are using Milliman criteria now, Cunningham says. Some use InterQual and others may use other criteria sets, including homegrown ones.

Case managers also need to understand the underlying implications of the contracts the hospital has with insurance companies.

Danza recommends that case managers work with the hospital's financial staff to ensure that the hospital continues to provide good patient care while protecting the financial interests of both the hospital and the patient.

His hospital system holds routine account meetings and denials meetings during which the financial staff and the case managers look at both the financial and clinical aspects of cases and brainstorm on issues and solutions. The meetings are held weekly at larger hospitals and every two weeks at the small hospitals in the system. They include representatives from admitting, insurance verification, patient accounting, finance, financial counseling, and case management to discuss active cases.

"We have a high level of interaction between the business people and the clinicians to make sure that the financial ramifications of clinical decisions are managed proactively," he says.

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. Add $9.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. 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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The discussions at the meetings are based on real cases. At the denials meetings, the team examines actual cases of discharged patients and discusses ways to avoid denials on similar cases in the future.

The high-risk meetings deal with patients who are in the hospital and whose condition or length of stay makes it possible that the insurance carrier may deny at least part of the care.

"The clinical situation always drives the decision about care but sometimes steps need to be taken to make sure we achieve the appropriate financial outcome. For example, we collaborate on a particular case to determine what things we ought to be doing so we can get the right reimbursement, or we may collaborate on a medically complex patient to make sure we anticipate financial roadblocks that may exist related to future discharge planning decisions," Danza says.

Every function has a defined role in the process and the discussions, he says. For instance, the admitting staff interact with the payers to make sure the insurance remains valid. The case managers present the substance of the case and the treatment plan, including how long the patient is likely to be in the hospital and his or her post-acute needs. The patient accounting department discusses how the hospital is likely to be paid and the financial risks of the case based on the individual payer involved.

"The meetings help us prioritize what the case managers need to do, so they don't, for example, have to spend time appealing denied days that will have limited or no financial impact. When a case is going to have a financial impact on the hospital, the case managers should be appealing the denials," Danza says.

Case managers have an obligation to their hospitals, as well as their patients, to help patients move through the continuum of care as quickly as possible, and to avoid unnecessary costs, Cunningham points out.

"The longer patients stay in the hospital, the more likely they are going to get sick from a hospital-acquired disease. In the future, when payments are decreased because of hospital-acquired issues, the hospital will have to absorb the cost of treatment," she says.

In its final rule, issued in August 2006, the Centers for Medicare & Medicaid Services (CMS) announced its intention to stop paying more for the care of patients who become infected as a result of their patient care than it pays for a patient who does not have a complication. In the interim, CMS has instituted a pilot project that requires hospitals in some states to track and report complications that were not present on admission. **(See the June issue of *Hospital Case Management* for a look at how hospitals in the pilot project have met the challenge.)**

Delays in service may affect not only the hospital's reimbursement but could create a burden for patients who have limited insurance coverage or are self-pay, Cunningham points out.

If case managers see a delay in service, their first communication should be with the attending physician. If that doesn't work, they should pass the information on to their physician advisor.

Collecting data on delays in service and aggregating those can be useful in changing physician behavior, she says. For instance, if a surgeon keeps a hospitalized patient waiting for surgery for three days and it happens just once, that's a lot different from a physician who constantly delays surgery, she says.

Help patients avoid unnecessary costs

Case managers have a responsibility to advocate for their patients and help them avoid unnecessary costs during their hospital stay, Kizziar says.

Case managers should try to influence practice patterns of physicians by utilizing evidence-based practice guidelines, she says.

Cost avoidance is another area where case managers can act as advocates for their patients by helping eliminate tests or procedures that are unrelated to the reason that patient was admitted and are likely to be denied by an insurer.

For instance, a physician may order a colonoscopy for a patient who was hospitalized for pneumonia because the patient never had one.

If the procedure isn't related to the pneumonia and the patient isn't having any symptoms that would warrant a colonoscopy, the insurance company isn't going to pay for the extra days in the hospital while the patient prepares for the procedure, she adds.

"The case manager should go to the doctor and suggest that the discharge orders include the information necessary for the patient to have the colonoscopy on an outpatient basis," she says.

If it's a Medicare patient, the extra days for the procedure can have a dire effect on reimbursement, Kizziar points out.

For instance, if the hospital's reimbursement for the pneumonia DRG is $20,000 and the cost of

treating the pneumonia is $17,000, the hospital's profit is $3,000. But if you take the cost of the colonoscopy and additional days of room and board into consideration, it cuts into the hospital's profit or may end up costing the hospital.

Even if the patient has commercial insurance, there is a set sum of money to pay for their care over the year, or over a lifetime, and it's eaten away by having a test in the hospital that could be performed on an outpatient basis, she points out.

To take it a step further, suppose the patient is in her 70s and becomes so dehydrated from the diarrhea caused by the preparation that she falls and breaks her hip. A diagnosis that should have resulted in a five-day stay ends up with a much longer stay and a much higher cost. ■

Be good stewards of patients' health benefits

Look beyond the current episode of care

When **B.K. Kizziar**, RN, CCM, CLP, speaks to groups of case managers, she asks if they know how many home care visits their own health care will provide. Few raise their hands.

"If we as health care professionals don't know our own benefits, how can we expect the patients and families to know what benefits they have for hospitalization and post-acute care?" asks Kizziar, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

"Our role is to find out the patient's benefits, whether it's commercial insurance, Medicare, Medicaid, or self-pay. We need to know what we have to work with. Otherwise, we may be recommending things that the patient simply cannot have," she adds.

In addition to affecting the reimbursement the hospital receives, the type of insurance a patient has will have an effect on his or her out-of-pocket expenses for a hospital stay, says **Beverly Cunningham**, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital.

"There is a responsibility to be a good steward of patients' resources among the entire treatment team but the coordination falls back on the case manager," Cunningham says.

Case managers need to know what coverage a patient has in order to tailor the treatment and discharge plan to minimize the out-of-pocket expenses, she says.

For instance, you may be coordinating the care of four patients with pneumonia, each of whom has a different kind of insurance coverage with benefits that have an impact on the optimum discharge plan. One may be on Medicare and can't go home with IV antibiotics because Medicare won't pay for it. The second one may have a PPO that will allow the patient to stay in the hospital as long as needed, based on their criteria. The third could have an HMO that wants to get the patient discharged as soon as possible and will pay for IV antibiotics at home. The fourth may have no insurance at all.

"Every one of these patients has a different financial responsibility at the end of the stay. Each insurer will pay a different amount and each patient will have different out-of-pocket expenses," Cunningham points out.

In order to plan a successful discharge, case managers also need to be aware of the patient's benefits outside the hospital benefit, Kizziar points out. For instance, a patient might benefit best from a skilled level of care but if he or she has no benefits, the case manager needs to find an alternative.

Case managers need to know what community resources are available to take up the slack when a patient can't pay for care after discharge.

"We often are interested only in the benefit for the care we're immediately managing but there are often far-reaching implications to our discharge plans," Cunningham says.

Take a step further

Take it a step further and look beyond what your patients need during the current episode of care and be a good steward of their benefits to assure that they will have coverage later on in the year, Kizziar says.

Take the patient's full benefit for post-acute care into account before setting up visits for home care or other post-acute services, she adds.

For example, patients with chronic diseases, such as chronic obstructive pulmonary disease often need home health visits after discharge.

If the patient only has 20 home health visits a year and you set up five a week for several weeks, the patient may end up having to pay out of pocket for a lot of home health expenses later in the year.

Look at whether the patient really needs daily

visits for four weeks or if he or she could have daily visits for a few days, then biweekly visits.

"If case managers look past the current situation to what the whole year may bring, we can be a better advocate for patients and help them maximize their benefits," she says.

Case managers also should pay attention to the maximum coverage a patient has and take steps to avoid delays in treatment that could result in excessive out-of-pocket expenses, Cunningham adds.

"There are situations where patients may have a maximum of $20,000 coverage for the year. If a patient in this situation ends up staying in the hospital for extra days because his or her physician doesn't schedule the surgery in a timely manner, or there are delays in getting the results of tests, the patient could end up being responsible for a huge bill," she says. ■

Documentation project increases case mix

Initiative to capture comorbidities, complications

Before Mountain States Health Alliance began its documentation improvement project, an outside consulting firm reviewed the hospitals' records and estimated that the Johnson City, TN-based hospital system had the opportunity to increase reimbursement by $5 million to $6 million annually with a documentation improvement program.

It's too soon to have any cost-saving statistics, but since the documentation improvement program began on July 1, 2006, the case mix index has increased by as much as 8.3% at some of the hospitals, according to **Debbie Cook**, RN, director of patient resource management for the health care system.

As patient resource management director, Cook is responsible for case management and social services at each hospital.

Before the hospital system started its documentation enhancement program, Johnson City Medical Center's case mix index was very low compared to facilities of similar size.

"We knew we couldn't be treating patients that were any different from those at the hospital down the street but their case mix was a lot higher than ours. This represented an opportunity to improve documentation so that the medical record clearly describes the patient illness," she says.

The administration made the decision to have the case managers spearhead the documentation enhancement project.

"My philosophy is that the case managers are the key people who can take on the documentation enhancement process. They're already in the charts and they already have a relationship with the physicians," she says.

The hospitals in the Mountain States Health Alliance have a physician-based case management model.

"The case managers are already working with the physicians on a daily basis. They have a rapport with them and are in a good position to educate the physician on what documentation is needed," she says.

The hospital administration considered adding RNs who were dedicated documentation specialists and decided against it, Cook says.

"That would mean there was another person that the physician had to deal with on a day-to-day basis. The case managers were in the best position to take on documentation enhancement," she says.

At Johnson City Medical Center, the organization's flagship hospital, her staff include RN case managers, social workers, LPNs who assist in discharge planning, a staff in charge of commercial payer precertification, and clinical appeals and denials staff who handle all appeals. "A good case management department can handle a multitude of roles, but there have to be enough staff to get it done," Cook says.

In order to ensure that the case managers had time to take on the additional duties, she set out the key responsibilities for case management — those were admission and continued stay, resource management, documentation improvement, quality, and supervising the discharge plan.

"We determined from the start that case manager caseloads needed to be between 20 and 25 for them to be able to handle all these tasks and do them well. We hired more staff and had the social workers and precertification staff assume a few more responsibilities," Cook says.

She shifted some of the case management duties, such as the majority of discharge planning tasks, to the social workers.

"We gave the case managers the responsibility for supervising the discharge plan. They passed on information they gathered when they interviewed patients to the social workers but the social workers assumed must of the discharge planning piece," Cook says.

The hospital system hired Pershing, Yoakley & Associates, a Charlotte, NC-based health care consulting firm, to provide classroom and on-the-job training for the case management staff.

"We considered hiring an external company to come in and take care of the entire program but we felt we had enough resources internally to put together our own program," she says.

Case managers from all the hospitals in the system came to Johnson City Medical Center three days a week for four-hour classroom sessions. Staff from the consulting firm shadowed them in the afternoons as they worked on documentation enhancement while performing their usual case management duties.

The hospital system arranged to videotape the training sessions to be used in ongoing training with new staff to give them basic information.

Following the training, the hospital system hired a documentation improvement specialist, with a background in coding and medical records, who works corporationwide and rotates between hospitals, providing training for new employees and conducting ongoing training for case managers.

"When external programs come in and provide training and software, what you don't get is ongoing education unless you pay for it. We wanted someone on board who could train new employees and keep everyone up to speed on changes in documentation requirements," Cook says.

In addition, the hospital purchased coding tools and other resources for each case manager's computer as well as reference books.

Before the project started, the case management and finance department worked together to come up with areas on which to focus. The hospital purchased Medicare Provider Analysis and Review (MEDPAR) data and benchmarked the hospital system's data against those to set goals for the project.

"We separated the data into service lines and looked at our rate of capturing complications and comorbidities [CCs] compared with the national database. We wanted to know where we ranked as far as case mix index compared to other hospitals," she says.

One of the main goals of the project is to concentrate on making sure that any comorbidities and complications are documented in the chart so that a higher DRG can be assigned, if appropriate.

When the case managers review the medical records for admission status and continued stay, they assign an initial DRG on their own worksheet based on the documentation, along with what they think the DRG could be based on the clinical information on the chart.

CMs, coders should work together

The case managers and coders meet once a month to talk about cases and why they should be coded a particular way. The coding staff attended some of the training sessions so they would be familiar with what the consulting firm was teaching the case managers, Cook says.

"Medical records and coding are key pieces in any documentation enhancement initiative. We had them on board from the get go. We have developed a wonderful relationship with our coding staff and call on them on a regular basis. We, as nurses, have something to offer them in terms of our clinical knowledge and expertise. We don't profess to be coders but we have the basics under our belts," she says.

Because the case managers are assigned by physician and specialty, each case manager doesn't have to learn all of the documentation required for every DRG. They learn the basics of coding and concentrate their efforts on their particular specialty.

The case managers review the documentation for all their patients, regardless of payer.

"So many payers are moving to a DRG-based payment system that it's hard for us just to look at Medicare patients. When the case managers are looking at the chart, they aren't thinking of what kind of payer is involved. They are just thinking of improved documentation. We apply the same documentation improvement standards for all patients," she says.

Before the initiative began, the hospitals' physician advisors met with the physician groups and explained the documentation improvement program, its goals, and why the hospital was undertaking it.

The case managers also conducted one-on-one training with the physicians.

"The physicians concentrate on providing care for the patients and they rely on the case managers to help prompt them to follow all of the coding rules," she says.

For instance, the term "poorly controlled diabetes" can't be coded. It needs to be written "out of control diabetes" on the chart.

When case managers have questions about documentation, they talk to the physicians face-to-face

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CRITICAL PATH NETWORK™

Get creative in dealing with long-stay patients

Tertiary care hospital frees beds for other acute cases

Through the efforts on an interdisciplinary team, the University of Wisconsin Hospitals and Clinics has been able to shrink the number of patients who remain in the hospital for 30 days or longer from an average of 60 or 70 in-house each day to an average of 20 or fewer.

As a tertiary care hospital, the University of Wisconsin Hospital receives patients that need specialized care from other hospitals all over the state. Many of the long-stay patients are trauma patients with complex head injuries or patients who have undergone transplants.

In the past, many of the patients have stayed at the University of Wisconsin Hospital for 30 days or longer even though they no longer needed specialty care, says **Barbara Liegel**, RN, MSN, director of coordinated care for University of Wisconsin Hospitals and Clinics in Madison.

Now, following a series of initiatives aimed at improving throughput, the hospital transfers many of the patients back to the referring facility after treatment or finds creative discharge solutions in the community.

"The level of acuity of the patients we treat is what turns many patients into a long-term stay patient; but keeping them for long lengths of stay impacts our capacity. It's not that we don't want these patients, but we have to open up beds so we can continue to serve patients with specialized needs," Liegel says.

A multidisciplinary team meets weekly to discuss patients with the potential for a long stay and looks for solutions. The team is chaired by case management and social work and includes representatives from admissions, the therapy staff, the legal department, physicians, palliative care, and the access center team, the hospital department that is accountable for admitting patients from referring hospitals.

"By participating on the committee, the access center staff learn what happens if a patient is not appropriate. Having them on the team makes them aware of the challenges with patients who are difficult to place," she says.

The team began by identifying the types of patients whose stays exceeded 30 days so that everyone in the organization would recognize the type of patients whose care needs to be managed, Liegel says.

At the recommendation of the team, the hospital updated all of the hospital transfer agreements with referring hospitals so that when the patient's tertiary care needs are completed, he or she is transferred back to the receiving hospital.

"Even on admission we talk to the transferring hospital and let them know that when we finish meeting the specialized needs of that patient, we are going to transfer them back," she says.

Holding referring hospitals accountable

In the past, many of the patients transferred for specialized care ended up staying at University of Wisconsin Hospital, Liegel says.

"We've done a fair amount of push-back. Some of the facilities don't want these patients back because they are hard to place. With the support of our senior management and the contracting team, we're holding our partners accountable for their patients. We tell the referring hospitals that we need to free up beds so that we will be here for them when they have a complex case," she says.

At the weekly meeting, the case management team gives a brief summary of each patient's status, including whether he or she still is meeting acute care criteria, and discusses the problems with discharge planning.

The entire team brainstorms to find solutions to the challenges the hospital faces in placing the patients. The team typically discusses patients who have been in the hospital 20 days or longer.

However, sometimes staff members may bring up patients with shorter stays who have the potential to become long-stay patients.

"Being in the hospital for days and days isn't the only solution. There are several kinds of alternative managed care home care situations in our city for young disabled patients and one for the elderly. They provide assistance with our creative care planning," Liegel says.

LTAC provides more discharge options

The opening of a new long-term acute care facility (LTAC) in Madison has given the hospital another option for discharge, she says.

"This has made it easier to discharge patients to an acute care facility that provides care and support for patients requiring prolonged hospitalization," she adds.

Before the facility opened earlier this year, the closest LTAC was more than an hour away, which put a burden on families whose loved ones were discharged there, she adds.

"We struggle with placement. The long-stay patients are quite complex. We have established a good relationship with the local nursing homes so we can help support patients who are appropriate at the nursing home level of care," she says.

The hospital often continues its support for complex patients after they have been discharged to a skilled nursing facility.

"Once a patient goes to a skilled facility, we help problem solve and support the patient at that level of care. We are working with the skilled nursing facilities to elevate the level of care they can provide," she says.

The case managers often look for creative referrals for placement of some of the long-stay patients who no longer need an acute level of care.

"If the patient meets community care criteria, we have a case manager who works with the physician and nursing team to put a creative plan into place. A creative approach to discharge allows us to bring in a paying patient to fill the bed," she says.

For instance, a young woman from Illinois was transferred to the hospital after an automobile accident and needed to be on bed rest for six to seven weeks. She couldn't return home because she lived alone. She had no insurance. The hospital was able to place her in a group home and send out a home care agency to take care of her needs.

"She doesn't need an inpatient level of care and doesn't need a nursing home. Our choices were to leave her at the hospital for six weeks until she's ready to go to rehab or home or to look for a place in a less intensive setting," Liegel says.

The patient's workers' compensation company agreed to pay for her stay in the group home.

"Even if we don't get reimbursed for home care or durable medical equipment, it's more economical to pay for these patients to be in a less costly setting and open up the bed for paying patients who have acute care needs," she says.

The hospital's home care program has a home ventilator program that is an option for many patients on ventilators.

"If a patient has any chance of going home on a vent, we pull them into the program. We still need to set up home nursing and sometimes 24-hour nursing care is hard to find," she says.

Discharging to home

The team came up with a creative discharge plan for a long-term ventilator patient who was terminally ill. The woman wasn't competent to make health care decisions anymore, and her guardian didn't want to remove the vent in the hospital because she had promised the patient that she would make it possible for the woman to die at home.

"We sat around as a team and made the recommendation that we would arrange for transport home, support her at home, and disconnect the ventilator at home," Liegel says. Planning her discharge to home extended the patient's stay to well more than 30 days.

The committee arranged a family meeting and found a primary care physician in the community who was willing to go into the home. They arranged a home respiratory therapist and hospice care.

"It was a very creative solution to a unique situation," Liegel says.

The long-stay committee was developed as

part of a far-reaching initiative aimed at improving throughput and increasing inpatient capacity. The average length of stay has dropped by more than a day since the initiative began in 2002.

Even with the more acute patients, the University of Wisconsin Hospital's average length of stay of 5.4 days compares favorably with a local community hospital with a length of stay just above four days.

"They have obstetrics, which typically means short-stay patients, and we do not," Liegel says. ■

Case manager coordinates care for injured workers

She is liaison between employee, employer, insurer

When injured workers come into Detroit Receiving Hospital's Level 1 trauma center at the Detroit Medical Center, their care is coordinated by a dedicated occupational health case coordinator who acts as a liaison between the emergency department's medical care team, the employee, the employer, and the workers' compensation carrier.

"A lot of injured workers have never had a work-related injury and don't understand how workers' compensation works in Michigan. I'm someone who the injured worker can contact if they have questions and concerns throughout their treatment and recuperation. It's much easier when workers and employers have one person to contact," says **Wanda Vesey**, RN, occupational health case coordinator for Detroit Medical Center's occupational health services department's fast-track program.

Vesey monitors the care of all injured workers who come through the emergency department as well as those who are referred for follow-up care at the hospital's occupational health services clinic.

Hospital contracts to treat workers

The hospital has contracts with major Detroit employers to treat workers injured on the job and to provide pre-planned assessments, drug and alcohol testing, and international travel health services. Smaller companies, which do not have a contract with the hospital, also refer their injured workers to Detroit Receiving Hospital's emergency department.

The occupational health services clinic sees an average of 75 patients a day. In addition, Vesey monitors and facilitates the care of an average of five to eight patients who are treated in the emergency department.

The key to the fast-track program for injured workers is having a dedicated case manager who works exclusively with injured workers. This helps move them smoothly through the continuum of care and get them back to work as quickly as possible while keeping the employers and third-party administrators or workers' compensation insurance carriers informed, Vesey says.

She coordinates the care of the workers from the time they reach the emergency department until they are discharged or admitted to an inpatient unit. She arranges for other outpatient services, such as physical therapy and MRIs, or follow-up appointments with specialists and gets authorization for the visits in advance.

Being in the know

Having someone who is familiar with Michigan's workers' compensation administrative rules and regulations is helpful since the paperwork requirements and regulations are different from those commercial insurers, Vesey says.

For instance, any follow-up care has to be authorized by the employee, a requirement that can be confusing.

"Many injured workers don't understand, in our state, the employer directs who provides medical care for the first 10 days following the injury. I find out where the employer wants them to go, whether it's to our clinic or another provider clinic. I educate the employees about the process and continue to be a liaison between the employer and employee during the recuperative period," she says.

Vesey is notified whenever an injured worker comes into the emergency department by way of an automated notification system that is linked to the hospital's registration system and electronic medical record. She also responds to calls or pages from the emergency department registration office.

"I meet the clients and occasionally their families in the emergency department, give them my card, and let them know that someone is here to answer their questions and help them navigate the process," Vesey explains.

She contacts the human resources department at the patient's place of work, alerts them that the

worker is being treated, and gets information about the workers' compensation carrier. She finds out what information the insurer wants, compiles it, and faxes or e-mails the information to them.

"Sometimes an injured worker hasn't filled out an incident report. I get them to do so and forward the information to employer or the third-party payer if they want the information," Vesey says.

She obtains authorization for follow-up treatment from the workers' compensation carrier, gets information on billing and where the medical records should be sent, and passes the information on to the emergency department registration officer.

"I keep the employer informed about the status of the patient and provide ongoing reports to all of the parties," Vesey says.

Coordinating transfers

Because Detroit Receiving is a Level 1 trauma center, injured workers may be transferred from other hospitals, particularly those with head injuries or those who need to be treated in the burn unit. In those cases, Vesey makes sure that Detroit Receiving Hospital has all the medical records from the transferring facilities.

When she arrives for work each day, Vesey picks up a printout of all workers' compensation clients who came to the hospital the previous day and checks their status.

If the worker came to the emergency department after hours, Vesey contracts the employer and verifies that the injury was work-related, then notifies the workers' compensation carrier.

If patients have been treated and released, she follows up to make sure they keep their follow-up appointments and informs the employer of any work restrictions.

"I contact the employer and the employee and get whatever authorization is needed for any follow-up visits or consultations with specialists," she says.

Post-discharge care

If the workers don't have an occupational health clinic at their place of employment, Vesey arranges for them to go to the Detroit Receiving Hospital occupational health clinic for follow-up.

"When I contact employers and third-party payers about follow-up visits, I send a marketing packet about our services if they don't have an occupational health clinic on site at the company," she says.

When injured employees are admitted to the hospital, Vesey passes on all the information she has collected, such as contact information for the insurance carrier, to the trauma care case managers.

"We work as a team. At our hospital, discharge planning starts on the first day. I get as much information as I can to help the case managers on the unit start immediately to take care of the patient's needs," she says.

Vesey then notifies the employer about the hospitalization and the unit on which the worker has been admitted.

Vesey keeps the employer apprised of the worker's return-to-work status. She sets up any referrals for additional services, such as an MRI or a physical therapy consultation.

"I get an authorization letter ahead of time and gather any other information the patient needs for the specialist visit. I alert the employer so that the worker can get time off to go to the appointment," she says. ■

Case continues: Was man discharged too soon?

HCCC investigates hospital

The Health Care Complaints Commission (HCCC) will continue to investigate charges that the Dubbo Base Hospital failed to follow up on blood test results in a patient who died a year ago from a heart infection.

The patient's mother, **Doreen Dawson**, says her son's death could have been avoided if he was kept in the hospital until the test results arrived. According to an *ABC News* story, the HCCC found that the emergency department's decision to discharge the 47-year-old man when they thought he had gastroenteritis "was not unreasonable."

Dawson says the commission will continue to seek more information.

"When he left the hospital, he had to be helped into a taxi and he could not stand up, and yet they said he was clinically stable when he was discharged," she says. ■

(Continued from page 70)

whenever possible. Otherwise, they post the questions on a special query sheet that they insert in the patient chart. The social workers also use the query sheet to leave notes for the physicians.

The query sheet is not a permanent part of the patient record. However, Cook uses it to compile data on physician compliance, whether they answer the queries and whether they agree or disagree with the case manager's suggestions.

Cook also tracks the number of DRGs with complications and comorbidities and breaks the data shown by physician specialty. She monitors the case managers and compiles data on the number of queries they make.

The hospital system monitors the difference between the final code by the coder and what the case manager thought the code would be to identify opportunities for education by the documentation improvement specialist. ■

After tornado, hospital able to place all in need

One hospital destroyed; another took up the slack

In the first weeks after a tornado destroyed Sumter Regional Hospital in Americus, GA, the case management staff was at loose ends.

"Our patients are being cared for by hospitals in the surrounding area. There's not much we can do in our ordinary role. We pitch in and do what we can to get the hospital services back on track," says **Rebecca Smith**, RN, BSN, director of outcomes manager/patient safety for the 143-bed hospital.

In the days following the tornado, the case managers were instrumental in arranging for the Red Cross and FEMA to provide disaster counseling for the hospital staff.

As soon as the hospital building was judged safe enough for people to enter, the case managers went room to room, gathering up whatever personal effects of patients that could be salvaged.

"We organized home visits to these patients to give back the personal belongings that we could salvage," she says.

During the home visits, the case managers interviewed the patients to find out what their needs were and helped them access whatever community services still were available, she adds.

When the tornado roared through South Georgia about 9 p.m. on March 1, hitting the hospital directly, the staff already had moved their patients away from the window and into the halls, away from flying debris.

When word got out that the tornado had hit the hospital, nurses, physicians, and other people in the community poured into the hospital to do what they could to help, some walking for miles to get there.

Sumter Regional had to hold the patients for two or more hours after the tornado hit because the roads surrounding the hospital were blocked by fallen trees. It gave the staff the advantage of being able to gather patient records and allowed the receiving hospitals time to prepare for an influx of patients.

While the nurses gathered the patient information, the emergency department physicians worked to triage the patients to surrounding hospitals.

Throughout the night, the emergency room at Sumter Memorial also was dealing with an influx of patients who had been injured in the tornado. Some walked to the hospital from their homes, which had been destroyed.

"Unless they needed to be stabilized, we transported them to other facilities," Smith says.

Some patients, who were stable, were transported by bus. Others went in ambulances provided by ambulance companies from existing communities that came to the scene.

As people from the community brought their chain saws and joined crews from Georgia Power to help clear the roads around the hospital, the staff at Phoebe Putney Memorial Hospital, 40 miles away, put its disaster plan into effect.

The 443-bed hospital called in personnel from each unit to handle patients who were being transferred from Sumter Regional as well as people injured in the storm who were coming in to the emergency department, says **Lynda Hammond**, MBA, FACHE, vice president of operations at Phoebe Putney.

"It was to our advantage that the tornado occurred when it did because our central intake and assessment office, which includes bed placement functions, was still staffed," Hammond says. That office, which typically closes at 11 p.m., stayed open until the wee hours of the morning placing patients, she adds.

The hospital opened up its short-stay area to use as a triage and evaluation area for the incoming patients.

When **Jeanette McDowell**, RNC, MSN, manager of the central intake and assessment center, arrived at the hospital at about 11:30 p.m., she immediately checked the hospital census to determine what beds were available.

"I wanted to determine how many patients we could safely accommodate, and whether the beds available in semi-private rooms were male or female beds," she says. McDowell also looked at semi-private rooms that had been "blocked," designated as private rooms because of patient preference.

"In a disaster, patient preference doesn't count. We ended up unblocking some of those rooms to free up beds for the incoming patients," she says.

In addition to the patients being transferred from Americus, the hospital's emergency department had a steady stream of other patients who came on their own.

"We were treating the people who came into our emergency center with other illnesses and injuries, in addition to those transported from Sumter Regional. Americus was not the only place impacted. Newton, GA, just 18 miles away, had six deaths from the tornado," McDowell says.

Every patient who needed a bed was placed, Hammond says.

"We tightened up and put them where we could. I was amazed that we were able to find beds for that many patients. Our central intake department did an awesome job on throughput," Hammond says.

The Phoebe Putney medical records department is cataloging and holding the medical records of patients from Sumter Regional until the hospital is back in service.

"Not all of the patients were admitted. Some were evaluated and were able to go back to Americus," McDowell says.

CM called to handle communication

The hospital called in a case manager about 1:30 a.m. to arrange transportation for injured patients who were being treated and released, Hammond adds.

"Some people were brought in by bus and they had no way to get home. Because of the tornado, communications were difficult. The case managers arranged for taxis to take the patients back to their homes," she says.

The case manager also provided clean, dry clothing, food, and other necessities to discharged patients who needed them, McDowell says.

The weekend on-call case managers came in on Saturday and Sunday to facilitate the discharge of appropriate patients and free up those beds, Hammond adds.

The central intake and assessment office became a part of the care management department, under Hammond's supervision, just a few weeks before the tornado.

"We were still working out the kinks but the arrangement worked very well in a difficult situation," Hammond says.

Several weeks after the tornado, some areas of Sumter County were still without telephone service. Some case managers and other hospital staff still were coping with the loss of their homes and other belongings. An estimated 400 homes in Sumter County were destroyed or heavily damaged by the tornado.

Soon after the tornado, Sumter Memorial set up an urgent care facility, staffed around the clock, in a huge tent provided by the Georgia Emergency Management Agency.

"We are only taking care of the things we can manage within four hours. Everyone with more intense needs is transferred to other hospitals," Smith says.

Maternity patients were being transported to other hospitals. Oncology patients were transported by bus for treatment at Phoebe Putney.

The hospital administration was looking for alternative sites for services and to bring the hospital back on line at temporary sites until the facility could be rebuilt.

"The case managers are out of the loop right now. We're looking forward to the time the hospital reopens in a temporary building, so we can be able to care for our patients again," Smith says. ■

Cost biggest barrier to health IT adoption

Hospitals continue to accelerate their use of health information technology, with 68% reporting that electronic health records had been fully or partially implemented as of fall 2006, according to the American Hospital Association's second annual survey of hospital health IT use.

About one-half of hospitals shared electronic patient data with others in both 2005 (53%) and 2006 (49%). Their most common partners included

private-practice physician offices, laboratories, payers, and other hospitals.

Cost is the biggest barrier to greater adoption of health IT, with urban hospitals, teaching hospitals, and larger hospitals more likely to afford the investment, the survey found.

Forty-six percent of community hospitals reported moderate or high use of health IT, compared to 37% in 2005. Health IT use was determined by the number of clinical IT functions — such as medication order entry, test results review, or clinical alerts — a hospital had implemented.

The AHA points out that while recent Department of Health and Human Services rules have lessened obstacles posed by the physician self-referral and anti-kickback laws, hospitals have been concerned that, under Internal Revenue Services rules, helping physicians access and use health IT could affect hospitals' tax-exempt status.

The latest indication from the IRS, according to the AHA, is that the new HHS rules would not jeopardize hospitals' tax-exempt status. ■

ACCESS MANAGEMENT
QUARTERLY

Access, CM functions overlap for patient needs

'How do you get a control point?'

The clinical expertise of case management is increasingly being used in the access process; and in the next five years, many of the functions of the two disciplines will be consolidated, says **Karen Zander**, RN, MS, CMAC, FAAN, principal and co-owner at the Center for Case Management in South Natick, MA.

"Case management staff are being asked to run the bed board, to have somebody in admitting and registration, to have a utilization review person doing preauthorization and precertification," she adds.

That overlap only can increase as hospitals and health care systems grapple with the many ways in which patients access care, she suggests, citing a client that is a well-known tertiary medical center in a rural area.

CE *questions*

17. What year did CMS announce its intention to stop paying for injuries or infections that patients acquire during their hospitalization and has since instituted pilot projects to track conditions that were not present on admission?
A. 2005
B. 2006
C. 2004
D. 2003

18. According to B.K. Kizziar, RN, CCM, CLP, to plan a successful discharge, case managers need to know patients' benefits outside the hospital.
A. True
B. False

19. Mountain States Health Alliance determined that, in order to fulfill all of their responsibilities, case managers should have a caseload of ___ patients.
A. 15 to 20
B. 20 to 25
C. 25 to 30
D. 30 to 35

20. Because the roads were blocked by fallen trees by the tornado that destroyed the hospital building, Sumter Regional Hospital had to postpone transferring patients to other facilities for:
A. three hours or more.
B. one hour or more.
C. two hours or longer.
D. six hours or longer.

Answer key: 17. B; 18. A; 19. B; 20. 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. ■

"There are patients admitted from the emergency department, direct admits from physician offices, acute-to-acute transfers, and people coming in on helicopters," Zander says. "How do you control all these doorways to your center? Who decides who comes and when and what bed to put them in? The ED is pushing for beds and post-surgical [staff] are pushing for beds.

"The challenge," she notes, "is, 'How do you get a control point?' Do you keep having a variety of ways to get in or do you consolidate it?"

Adding to that challenge is the fact that the process goes on 24 hours a day, and that it involves an intricate mix of medical, financial, and regulatory concerns, Zander says. "The more people see that these are clinical discussions plus regulation plus reimbursement, the more case management will start to influence the access piece.

"In the old days," she points out, "if you needed a bed in off-hours, the nursing supervisor would canvas the hospital, decide what bed was available, and the patient would go there. Now it's much more complicated. There's a higher demand for beds and for immediate decisions."

While she believes that access will take on much more of a clinical judgment role, Zander says there is no clear answer as to whether the top decision maker in the process will come from the access or the case management arena.

"In my experience, the person that gets given this bigger scope is the person who has been successful in smaller scopes," she says. "The boss will be the person who has proved herself in other ways."

Zander says she could see a physician being part of access, especially at a tertiary medical center with direct admits.

In addition, she says, in the case of a health system clinical and support people should have the authority to place patients in beds throughout the system, not just at the facility where the patients present.

"There is a very cumbersome process now, where an acute rehabilitation facility has to send a representative to the hospital, assess patients, and then go back and see if they really have a bed," Zander notes. "I see all the middle stuff being cut out and, through clinical judgment and criteria, [intake staff] saying, 'It's time for acute rehab,'" and finding a place for the patient within that system.

That would be with the patient's permission, she emphasizes. "It all has to do with patient choice, but if patients choose that, and that's what they need, let's just get them there — or to a skilled nursing facility or home care [if that's what is needed]."

This could be a patient in the ED, or one currently in a bed, Zander notes, "but instead of having case management call agencies and say, 'Do you have a bed?' have one access person say, 'We have this bed [within the health system].' It takes a lot more personnel to have the process we have now."

[Editor's note: Karen Zander can be reached at (508) 651-2600 or by e-mail at KZander@cfcm.com.] ■

'Cognitive load' increasing for health care workers

It's 'brain flow,' not work flow

Something called "cognitive load" or "cognitive work" is the centerpoint of some of the latest thinking on the way people process information and do their jobs.

That research — by Patricia Potter, a nurse scientist at Barnes-Jewish Hospital in St. Louis who co-wrote the textbook "Fundamentals of Nursing" — concerns nurses, but can be extrapolated to case managers and other health care professionals, notes **Karen Zander**, RN, MS, CMAC, FAAN, principal and co-owner of the Center for Case Management in South Natick, MA.

"Pat is doing research with an industrial engineer," she says. "He is looking at work flow, but she is studying 'brain flow.' In clinical work, sometimes your body and mind are not in the same place."

The engineer measures when and where the nurses go, how much time they spend in each patient's room, and whether they are charting or performing another task, she explains. Meanwhile, Potter is studying what's going on in their brains, what they are filled with as they go from place to place or while in one place, Zander adds.

"The idea is that you hold a lot in your head," she says, "and it's different from multitasking, which is eating a sandwich, talking on the phone, and reading something on your computer screen at the same time."

Cognitive load is about how many activities and distinct pieces of information a person holds in his or her head at any one time, Zander continues. "It's the thinking that goes into the doing, the assessment, and judgment that comprise critical thinking."

In "regular life," the cognitive load may have to do with thinking about how much food is in the refrigerator and an errand that needs to be done and being interrupted by a phone call, she says. "In health care, it's high-level stuff."

As part of her research, Potter tracks the number of shifts people makes in their cognitive work as they go through the day, Zander says. "She's looking at how a nurse shifts from one to the other of four things: assessing, planning, implementing, and evaluating."

The findings were that a nurse had 82 shifts in thinking in eight hours, she notes. "When the nurse is in a room with a patient, and the patient is telling her about a pain in his side and she is asking questions, that's assessing. If she's starting to say things like, 'If you take deep breaths it might get better,' or 'I'll get you a pill,' that's implementing."

If the nurse goes back later and says, "Are you feeling better?" and "Can you walk now?" that's evaluating, Zander says. "If she says to another nurse, 'This seemed to work this time, but you might want to try another approach on the evening shift,' that would be planning."

In addition to the 82 shifts in thinking in eight hours, there were 42 interruptions, she says, after which the nurse had to return to her work. "That was a nurse with maybe five patients," Zander adds. "A case manager might have 15 or 20."

The industrial engineer concluded that the nurses spent an average of 30.9 minutes per patient room, she notes, but Potter found the cognitive work took another 15.7 minutes per patient, for a total of 46.6 minutes.

"[The cognitive work] is invisible to the eye, but it is the stress of what the work is," Zander says. "If that breaks down, if the person just can't carry all that in her head or can't get interrupted and go back, and loses focus, that's a safety issue." ■

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. ■

'Patient portal' designed for elderly patients

Preregistration function to be enhanced

A University of Arkansas for Medical Sciences (UAMS) project that began with the Center on Aging identifying a need to communicate better with elderly patients has become an ambitious Internet initiative encompassing the entire campus.

The Center on Aging, one of the UAMS Centers of Excellence, wanted a way to get elderly patients more involved in their own health care, specifically through an exchange between institution and patient that would tie into the electronic medical record system, says **Alan Gardner**, MBA, director of process and planning for the UAMS information technology (IT) department.

UAMS did a survey of its various departments to determine what functions they felt were most important to include in the patient portal, Gardner says, based on level of effort required to implement, as well as benefit to the patient and to the department itself in terms of cost savings.

Survey results, he adds, included the following functions, in the order in which they were ranked by respondents:

COMING IN FUTURE MONTHS

- ■ How hospitals are complying with the CMS "present on admission" initiative
- ■ Taking a proactive approach to patient admission status
- ■ Getting involved in your hospital's disaster plan
- ■ Strategies for cutting down on avoidable days

- preregistration;
- prescription refill request;
- appointment request;
- medications list;
- appointment viewing;
- patient education resources or links;
- requests for medical records;
- lab test results;
- medical conditions list;
- on-line bill or invoice viewing and bill payment;
- clinical care team list;
- secure patient-clinic messaging, with the nurse, physician, or appointment desk, and the integration of that messaging with the EMR system;
- ability to update insurance and registration information;
- a way-finding system that would be tapped into with the patient portal.

The project steering committee — a group of between 20 and 25 administrators, clinicians, and other interested parties that meets monthly — will determine what the policies and priorities are regarding the patient portal, Gardner says.

In addition to improving its own cash flow with on-line bill payments, UAMS thinks the patient portal will have the following benefits.

- improve patient satisfaction;
- get patients more involved in their own health care, in line with national initiatives such as consumer-driven health plans;
- reduce administrative costs;
- improve work flow through on-line preregistration and appointment requests. ■