HOSPITAL CASE MANAGEMENT™

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

AHC Media LLC

IN THIS ISSUE

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Get involved with your hospital's disaster planning initiatives

Case managers can pay a critical role when there are mass casualties

As your hospital engages in disaster planning, make sure that your case management department is involved in the process, **Beverly Cunningham**, RN, MS, associate administrator, clinical performance improvement, Medical City Dallas Hospital, advises.

"Hospital safety officers and other administrators may not be aware of how important the role of case managers can be in the event of a disaster. Case management leaders need to step up to the plate and be as involved as they can in hospital disaster planning," Cunningham says.

People tend to think that handling the influx of patients who come into a hospital following a natural or man-made disaster is the responsibility of the emergency department staff but the role of case managers is integral to the success of a disaster plan, she points out.

When a disaster strikes, case managers are likely to have a major role in facilitating discharges so that the hospital is able to accept a surge of patients, adds **Jeanne Eckes**, RN, MBA, director of emergency preparedness for the North Broward Hospital District, with headquarters in Fort Lauderdale, FL. "In addition, they may need to facilitate transportation home for patients, set up home care for people who need it, provide them with durable goods and other supplies," she says.

In fact, the accreditation standards for emergency management planning from The Joint Commission point out that "managing the flow of patients through the organization is essential to the prevention and mitigation of patient crowding, a problem that can lead to lapses in patient safety and the quality of care."

In a mass casualty situation, the resources a hospital needs to manage the influx of patients are likely to exceed the resources and staff on hand, Cunningham says. "The hospital doesn't just need emergency room staff and bedside nurses. It needs people to help free up beds for the new patients and help with people who are in shock and grieving," she adds.

Case managers are well suited to be in charge of planning and facilitating the discharge of patients in the event that the hospital has to be evacuated or patients need to be discharged to make room for patients injured in a disaster, says **Nathan Szenjniuk**, a member of the Center for Healthcare Emergency Response, based in Nashville, TN. He recommends that case managers meet with the hospital's disaster planner and physicians periodically to discuss ways to facilitate patient flow in a disaster. He suggests scenario-based planning exercises in which the hospital staff discuss what would happen in the event of a particular disaster, such as a flood, a tornado, or an earthquake. **(For more on scenario-based planning, see p. 116.)**

Case management directors should develop a department disaster plan and make sure that each employee is aware of his or her roles and responsibilities, Eckes advises.

In case of a disaster, case managers should expect to be called to triage patients or take on other duties. "The case managers need to be training in a number of different roles. They may be taken out of the case management role and placed in a different role if they are needed," she adds.

Case management directors need to think about where their staff are most likely to be needed in case of a disaster, Cunningham says. For instance, if the social workers typically are involved in discharge planning at your hospital, you need to designate who will counsel patients and family members after the disaster and who will be involved in discharging patients, she says.

"The biggest things that case managers need to know and understand in a disaster is how to do a quick look at patients and categorize who is available and who is not available for discharge," Cunningham adds.

Although Dallas was not directly affected by hurricanes Katrina and Rita, the hospital did go into minimal disaster mode to handle the influx of people being transferred from less safe areas. "When Hurricane Rita was headed toward our area and we thought we might have to empty the hospital, we sent through the hospital and gave every patient an assignment based on severity of illness," Cunningham says.

The case managers assigned every patient a priority number depending on their readiness for discharge. Patients who were a 1 could be discharged that day if needed. Those who were ranked 4 could not be discharged under any circumstances.

"We passed the information on to the nursing supervisor. If more patients had come in, they would have had some direction in identifying which patients might be discharged," she says.

Case management directors should make sure that their department's disaster plans are up to date and that each member of the staff knows what his or her responsibilities will be in the event of a disaster, Cunningham suggests.

Make sure that all telephone numbers and

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addresses for everyone on your staff are up to date, Eckes adds.

"The hospital needs to be able to get in touch with all employees in case of a disaster. If the case management director hasn't heard from an employee and can't get in touch, we need to have the correct address so we can do a welfare check," she adds.

Each department in every hospital at North Broward Hospital District has a communication tree that designates who calls whom in case of a disaster. The hospital system is exploring the possibility of an automatic dialing system to alert staff to come into the hospital, Eckes says.

Communication is integral

Communication is essential when a disaster strikes, Eckes says. "When case managers are getting ready to discharge patients, it's critical that they communicate the patient needs to the command center and get help in mustering up the resources that patient will need," she says.

After Hurricane Wilma struck the southeastern coast of Florida in October 2005, leaving some areas without power for as long as 20 days, the case managers delayed the discharge of patients who could not return to a safe location. They communicated the patients' addresses to the emergency operations center to make sure the power had been restored.

"We found out when the power would be restored and planned our discharge around that. If we knew that the power in a neighborhood would be back on in 12 hours, we knew we could safely discharge patients in that area," she says.

In addition to being prepared to pitch in and do whatever is necessary in a disaster, case managers should prepare themselves and their families for a disaster, creating their own personal preparation plan, Eckes advises. "I am a firm believer that everyone should have a preparedness plan, even for the most minor inconveniences like traffic tie-ups or road failures," she says.

Eckes encourages the hospital staff to have a family disaster plan and a family communication plan so that if they get stuck at the hospital the family will know what happened and they will know that their family is in a safe place.

Case managers should take the lead in talking with their patients about what they would do in the case of a disaster, Eckes says.

Make sure your patients understand evacuation plans and remind them to have a supply of medications and other necessities on hand, Eckes recommends.

"What may be a minor inconvenience for some people, like a power outage, can be critical for a number of individuals. That's why I always promote a personal preparedness plan and suggest that case managers encourage their patients to plan for disasters," she says.

The only way, though, to make sure your plan is working is to have practice drills and exercises, Eckes says. Her hospital system holds a variety of drills throughout the year. "We create an exercise plan with specific objectives; we may focus on one segment of the plan or the whole plan," she says.

During a full drill, the hospital system recruits several hundred students to act as victims and puts make-up on them to simulate injuries. The hospital system partners with fire rescue, law enforcement, emergency management, ambulance firms, and other organizations. As the victims come into the hospital, the treatment team treats them based on injuries they observe or tags attached to the "patients."

"When real incidents occur in the community, we critique our response to them as well and identify what lessons we learned and what changes we should make to our plan," she says.

Medical City Dallas Hospital had a disaster drill that simulated an avian flu epidemic when a family on a mission trip developed the disease and had exposed their fellow passengers on an airplane. "This scenario is different from a mass casualty. It has a slow onset and ebbs and flows over a period of months. We looked at how we would care for very sick people over a long period of time, how we could assure that we had the beds to handle other people exposed to the disease, and how we would counsel patients, their family members, and concerned people in the community," Cunningham says.

During its latest disaster drill in May, McLaren Regional Medical Center in Flint, MI, was alerted that it was about to receive 50 patients who were injured in an imaginary plane crash.

The case managers went to the units where the beds were most desperately needed and worked with the physicians to facilitate discharge.

After the drill, the staff sat down and discussed how the plan worked, says **Diane Kallas**, BSN, MBA, RN, director of case management.

"Knowing the staff, their areas of expertise, and what role each would be most useful in during an emergency is essential in the event of a disaster," she adds.

Here is some other advice on how case managers can be involved in disaster planning:

• Communicate with your hospital's safely officer and anyone else involved in disaster planning and make sure that case management is a part of what is being planned, Cunningham says.

• Make sure your department participates in hospital disaster drills, she adds.

• Meet with your staff often to talk about what would happen in the event of a disaster and let them know what their role would be, Kallas says.

• Come up with a game plan and run it by management so everyone will be in agreement, Kallas suggests.

"We all know what our individual roles are and what the department role is. We need to make sure it correlates with the organization's role," she adds.

Conduct a tabletop exercise just for your department with a disaster scenario and brainstorm on how it would be handled, Cunningham says. Gather up what you think your staff would need in the case of an emergency. For instance, the McLaren Regional case management department has created a disaster box with the disaster manual, sign-in sheets, and other materials that the staff may need in a disaster.

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Simulated disaster helps hospital fine-tune its plan

CMs worked to free up beds for influx of patients

When McLaren Regional Medical Center got the news that 50 people injured in an airplane crash were headed toward the hospital, the case management staff sprang into action.

In accordance with the Flint, MI, hospital's disaster plan, case managers left their unit and gathered in their department office to find out what happened, how many patients the hospital was expected to receive, and what kind of beds would be needed.

When the staff arrived, **Diane Kallas**, BSN, MBA, RN, director of case management and **Tamar Swain**, RN, BSN, MBA, manager of case management, assigned the case managers to units where beds were needed for the influx of patients. Their instructions were to work with the admitting physicians to determine which patients could be safely discharged to home or to another level of care.

The social workers on the units were sent to the emergency department to help family members get information about the injured patients. Kallas and Swain rushed to the emergency department to help with registration and do whatever else was needed.

The airplane crash on that day in May didn't really happen. It was a disaster drill, complete with mock "patients" from a local high school who were assigned simulated injuries.

"The 'patients' we saw during the disaster drill had the gamut of injuries you would see in a plane crash. The staff role-played and treated them just like we would in a real disaster. The exercise opened up a lot of ideas for discussion," Kallas says.

The hospital's disaster plan prepares the staff for everything from major automobile accidents and fires to plane crashes and environmental terrorism. A full-scale disaster drill is conducted at least once a year, Swain says. In between, the case management department regularly talks about its role in a disaster and how staff can best meet patients' needs during an emergency.

"Our safety office and quality experts update us and ask for our ideas about what we should do in specific situations. They communicate information from the community, what resources are available, and what role they play on the city and state level," Swain says.

In the event of a disaster, case managers may not necessarily be assigned to the units where they typically work, Kallas says. "We send the case managers where they are needed but we keep in mind where their areas of expertise are. For instance, we wouldn't send a case manager with little experience in critical care to the critical care unit," she says.

When the hospital got the announcement about the recent "disaster," Kallas and Swain went to patient registration to help obtain information

about incoming patients and track where they were being treated. They found that the patient registration department was well prepared for the disaster and didn't need additional help, except from the social workers who were there to help family members of injured patients find their loved ones. The hospital has pre-made packets that included physician orders, laboratory slips, and other materials the staff could use to quickly get the treatment process started.

The registration department keeps tracking sheets, showing the name of every patient who comes in and where they are sent so family members can be guided to the appropriate area.

"We stepped in, as RNs, and helped triage patients coming into the emergency room. That's not a typical case management role but in a disaster, all staff should be able to cross over and help wherever they are needed," Kallas says.

After the drill was over, the staff met and talked about what could have gone more smoothly and areas where improvements could be made. "Some of the areas were tagging vitals for lab work, making sure we identified patients with at least three identifiers, and what we do with patients who just have minor injuries, like wounds cleaned or stitches," she reports.

The nurses cleaned and bandaged the wounds of patients with minor injuries but they still needed to be examined by a doctor before they could be discharged. They were sent to the church school cafeteria across the street where they waited until the patients with more serious injuries had been seen.

At McLaren Regional Medical Center, the case managers are bachelor's-prepared RNs and are assigned by unit. They work as a team with social workers who are assigned to two units each. In addition, the department provides coverage in the emergency department from 11 a.m. to 12:30 a.m. seven days a week.

The case management department has worked hard to develop a close working relationship with the physicians and the nursing staff, an effort that pays off every day but will be especially helpful in the event of a disaster, Swain says.

"We feel like we are the allies of the doctors and we work with them as a team. We make rounds with the nurses and use the opportunity to teach them how case management can help them. Our goal is that when someone calls our department, we'll answer any question they have or take care of any problem. We want that to be the last phone call they have to make," Swain says.

The case managers meet with staff on their units three days a week to identify patients who could go to the next level of care and work to overcome the barriers to discharging them.

On the other two days, Swain convenes a multidisciplinary team that includes case managers, social workers, and representatives from the hospital's long-term acute care facility and rehabilitation center.

"Each unit reports on their patients, why they are here, what their functional level is, what their chances are of getting back to their previous functional level, and what we have to do to help them get there," Swain says.

If a disaster strikes, the case managers already will have a good idea of which patients could be discharged to free up beds for injured patients, Kallas points out. Hospital plans call for the case managers to work with the physicians to discharge patients who can be safely moved to another level of care. They may call nearby nursing homes to find out if they can take some patients on a short-term basis.

"Everybody has to work together in a disaster. We stay in close touch with the hospital incident command center, which is coordinating all of the aspects of the disaster," Swain says.

In the event of a disaster, the case managers will alert Kallas or Swain if a patient can be discharged and either they can't get in touch with the physician or the physician won't agree to the discharge. The information will be relayed to the executive team, which includes physicians who can make an administrative decision to discharge the patients.

"I can see the case managers playing a big role in a disaster by pulling the staff together. We are familiar with the big picture and the entire continuum of care and have the ability to pull all the resources together," Swain says. ■

Hospital helps chronically ill prepare for disaster

CMs make sure eligible patients sign up for shelters

As hurricane season approaches each year, case managers in North Broward Hospital District's disease state management programs work with their patients to make sure they will be safe if a storm hits the area, causing flooding and power outages.

Patients without insurance and some Medicaid patients are eligible for the Ft. Lauderdale, FL-based hospital system's chronic illness program for patients with diabetes, asthma, hypertension, congestive heart failure, HIV-AIDS, breast cancer, and high-risk pregnancies. The program is part of the North Broward Hospital District, a health care system that includes five acute-care facilities and 11 primary care sites.

Case managers, located in the health system's primary care clinics, work with patients to help them understand and learn to manage their disease. They work on medication adherence, remind them of follow-up doctor appointments, and educate them on tests and procedures, such as eye examinations for diabetics.

"One of the goals of our case management program is to keep our patients healthy and help them avoid hospitalization or trips to the emergency room. As part of the program, we help them be prepared for a hurricane so they can stay healthy in the event of flooding or power outages," says **Lori Kessler**, BSW, MHSA, district manager for the disease state management programs.

Many of the elderly, unfunded, and underserved patients in South Florida live in trailer parks, which are particularly vulnerable in bad weather. "As we approach hurricane season, the case managers find out where their patients live and determine if there is an evacuation plan and if there is a shelter in the area," Kessler says.

They make sure that patients in low-lying or otherwise vulnerable areas are registered either with American Red Cross or medical shelters in the area. The case managers concentrate on the patients who live closest to the ocean in areas where there is a higher risk of flooding. If the patients are medically fragile, or need oxygen, the case managers make sure they are registered for a medical shelter where they can go during a storm. They provide their patients with the telephone number and location of the shelter and encourage them to go there before the storm.

"We encourage them to keep enough medications so that they can take care of themselves when they are out of the home. The shelters have a full medical team to ensure the patient's safety and well-being during the storm," she says.

The case managers make sure that all of their patients who qualify for a medical shelter or a Red Cross shelter are signed up with the shelter. If patients elect to remain in their own homes, case managers make sure they have enough food, water, and medication to last a week. They educate patients on items they should stock up on, such as batteries, bottled water, and enough food to last a couple of weeks.

"We try to be sensitive to what the patients can afford. We give them lists of foods that they can relate to and urge them to stock up on those," she says.

For instance, since Latin and Caribbean diets typically include beans and rice, the case managers would recommend that these patients buy canned beans and packages of pre-cooked rice, rather than things such as peanut butter or granola bars.

The nurses remind all of their patients to keep enough of their medication in stock in case they are homebound following a storm. They educate them on the necessity for good hydration and diet during a flood or power outages.

After the storm subsides and the health centers reopen, the case managers get in touch with their patients to make sure they are OK and to assess whether any urgent medical issues have come up during that stressful time, Kessler says.

*(For more information, contact **Lori Kessler**, BSW, MHSA, district manager for disease state management programs, North Broward Hospital District; e-mail: LKessler@nbhd.org.)* ■

Prepare for disaster with scenario-based planning

Scenario-based planning helps cover contingencies

You're a case manager in an ICU unit and your hospital is in the path of a Category 5 hurricane. How do you make sure your patients get to safety?

Or, you coordinate care for patients in an orthopedic unit at a hospital that is near a major dam that's about to break. Some of your patients must remain immobile following surgery; others who are almost ready for discharge live in a low-lying area. What do you do?

Suppose there is an earthquake. How will you get your patients moved out of harm's way when the roads are impassible?

Case managers can help their hospitals come up with solutions to these and other potential disas-

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CRITICAL PATH NETWORK™

Quality measures gain importance as CMS moves to value-based purchasing

Payments will be linked to quality, not just delivery of service

As the Centers for Medicare & Medicaid Services (CMS) moves toward its value-based purchasing initiative, case managers are in a position to help their hospitals prepare for the time when payment will be linked to quality, rather than just delivery of service.

CMS is authorized through the Deficit Reduction Act of 2005 to have a plan for value-based purchasing in place by 2009, points out **Carolyn C. Scott**, RN, MEd, MHA, director of KPMG's health care advisory practice.

Value-based purchasing (VBP) links payment to quality, rather than just the delivery of service, Scott points out. The initiative ultimately will replace the current hospital quality reporting system and will include both public reporting and financial incentives to drive clinical quality, Scott says.

In the interim, CMS has added six new quality metrics, for a total of 27, which hospitals must report to avoid a 2% reduction in the payment update for Medicare patients in fiscal year 2008. As part of the Deficit Reduction Act of 2005, beginning with discharges that occur on or after Oct. 1, 2008, CMS will begin to eliminate additional payments for some complications of care that occur after a patient is admitted to the hospital.

CMS is expected to start requiring hospitals to incorporate the "present on admission code" on all DRGs, starting in October 2007, but has not yet published an official deadline.

The "present on admission" reporting will include five options that must be included on all diagnoses:

- **Y** for yes;
- **N** for no;
- **U** for "no information in the record";
- **W** if it can't be determined clinically;
- **blank** if the condition is exempt from "present on admission" reporting.

When the value-based purchasing initiative is implemented, a specified percentage of a hospital's payment from CMS would be based on the hospital's performance on the VBP incentive payment measures.

CMS is working with a task force to develop measures that will be included in the initial round of quality measures in the value-based purchasing initiative. The agency is considering excluding from the current quality measures those on which hospitals are already performing at high levels and those around which there is some controversy, Scott says.

For instance, CMS is considering not including for value-based purchasing incentive pay the requirement for administering beta-blockers at arrival for AMI patients because the measure is under evaluation by the American College of Cardiology and the American Heart Association and may need "stability" prior to inclusion in the program, Scott says.

It is proposing to remove oxygenation assessment for pneumonia because there is little opportunity for hospitals to improve their compliance, according to CMS in its proposed measure set for the value-based purchasing program.

In the meantime, beginning Oct. 1 2007, hospitals will be required to publicly report data on

new performance measures included in the Surgical Care Improvement Project (SCIP), 30-day mortality measures for acute myocardial infarction and heart failure Medicare patients, and results of a survey that measures the patient experience.

The three new measures that are part of SCIP include venous thromboembolism (VTE) prophylaxis ordered, VTE prophylaxis given within 24 hours of surgery, and appropriate antibiotic selection for surgery patients.

"As with other process measures, case managers can take a role in ensuring their hospital's compliance with the VTE prophylaxis measures by examining the patient record to make sure that the order was written and that the prophylaxis is given in a timely manner and that the documentation reflects that it has. If this hasn't occurred, the case managers should prompt those who are responsible to ensure that the hospital complies," Scott suggests.

CMS can help ensure compliance

While case managers cannot affect the appropriate antibiotic selection for surgery patients, they can take action retrospectively by analyzing the reports to determine any patterns in failure to comply, such as the practices of specific surgeons. In addition, case managers can make sure that the documentation shows that the antibiotic selection falls within guidelines and, if it does not, that the reason why is documented. CMS has added the 30-day mortality measures for AMI and heart failure Medicare patients to encourage hospitals to evaluate what happened during the episode of care of patients who did not survive and determine if anything could have been done differently, Scott says.

Depending on their size, hospitals will be required to submit between 100 and 300 survey results from the 27-item Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

The HCAHPS measures patient perception of care in seven categories that include nurse communication, physician communication, responsiveness of hospital staff, communication about medicine, cleanliness and quiet of hospital environment, pain management, and discharge information, along with two questions about overall quality of care and whether patients would recommend the hospital to others.

The surveys may be completed by telephone, mail, or a combination, Scott says.

Beginning in the first quarter of 2008, patients will be able to go on-line and see how other patients rated their hospital experience along with other Hospital Compare data, Scott says. CMS also has announced its intention to add at least five new metrics in FY 2009 and has solicited comments on 32 different metrics/measure sets it is considering for 2009. The comment period on the proposed measures ended June 12.

In addition to linking a portion of a hospital's payments to quality in fiscal year 2009, the Deficit Reduction Act of 2005 requires CMS to stop paying for some complications of care that developed during the hospital stay, Scott points out.

CMS considering complications

CMS has not yet selected what complications of care will be included but has announced the top six complications under consideration, Scott says, which are:

- catheter-associated urinary tract infections;
- pressure ulcers;
- objects left in during surgery;
- air embolism;
- blood incompatibility;
- *Staphylococcus aureus* bloodstream infection/septicemia.

The act requires CMS to select at least two complications of care using the following criteria: complications with a high cost, a high volume or both; a complication that results in a DRG that has a higher payment when it is present as a secondary diagnosis; and a condition that could have been prevented by use of evidence-based guidelines.

For instance, CMS reports that there are 561,667 catheter-associated urinary tract infections a year and that in fiscal year 2006, there were 11,780 reported cases of Medicare patients who had a catheter-associated urinary tract infection as a secondary diagnosis.

CAUTI considered a complication

According to CMS' figures, hospital-acquired urinary tract infections resulted in nearly 1 million extra patient days a year at a cost of $424 million to $451 million.

"We believe the condition of catheter-associated urinary tract infection meets all our requirements for selection as one of the initial hospital-acquired conditions. The condition is a complication or

comorbidity under both the current and the proposed-MS-DRGs . . . The condition meets our burden criterion with its high cost and high frequency," CMS said in its proposed inpatient prospective payment system rule for 2008.

CMS also pointed out in the proposed rule that there are widely recognized guidelines for the prevention of catheter-associated urinary tract infections.

"The Deficit Reduction Act is written to make it clear that CMS is not going to pay for poor quality care. These adverse events can be tied to poor quality care," Scott says.

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Social worker/CM handle babies for moms

Job entails both medical and social issues

Barbara Zielinski, MSW, CCM, does double duty as a case manager and social worker on the women and children's services unit at Ingham Regional Medical Center in Lansing, MI, working with children's protective services or adoption agencies to place some of the infants born at the hospital.

"In other areas of the hospital, the utilization review and discharge planning piece is handled by the RN case managers. On this unit, the patients tend to have so many psychosocial issues that the decision was made to have a social worker coordinate the care of the patients," she says.

The arrangement has been very successful because Zielinski can take care of her patients' psychosocial needs as well as coordinating their care, she points out. "Many of the newborns and/or their mothers have multiple needs. The physicians find it easier to deal with one person rather than a case manager and a social worker," she says.

Zielinski has received training on InterQual criteria for her patient population and utilization review training by the utilization review supervisor. She handles discharge planning for her patients, working with home care agencies and the public health nurse liaison from the country public health department.

"A major part of my work is moving patients through the hospital stay in a timely manner. Coordinating with physicians, nurses, and community agencies is an essential part of my job," Zielinski says.

When she sets up an assessment by children's protective services, an adoption, or a referral to home care, she tries to time the discharge for a time when the patient is stable and the discharge will be safe. "I work to make sure everything is in place so there won't be a delay in the discharge," she says.

Zielinski's patient population includes the birthing center, women with pregnancy problems who have a hospital stay before delivery, pediatric patients, and gynecological medical-surgical patients. She has an average caseload of about 24 patients at a time.

"In the course of a week's time, I see a half-dozen patients who need intensive social work. The bulk of these patients are in the birthing center," she says.

Among these are teenagers who have babies, families with domestic violence issues or unsafe home situations, women at risk for postpartum depression, children or teenagers who have attempted suicide, and women with mental health problems such as schizophrenia, who have delivered babies.

"I receive phone calls from all over our community, such as local foster care agencies or a public health nurse liaison, alerting me to situations where a child may be at risk," Zielinski says.

Accessing patients

Patients who may have psychosocial needs are identified during the nursing staff's thorough assessment of all new patients. The assessment of obstetric and pediatric patients is geared specifically to that patient population. "The nurses are trained to inquire casually about other children to determine if the mother may have lost custody. I get calls from across the community alerting me to situations when a family needs an intervention," Zielinski says.

If Zielinski or the nursing staff are concerned about mother-infant bonding or an unstable home situation, she makes a referral from the hospital for home visits for infant mental health services or family outreach services. The hospital has a protocol to screen both the mothers and the newborns for illicit drugs if they present with certain risk factors.

"We do the screen for the safety of the mother and the baby. If the newborn has been exposed to drugs, we need to know so we can provide medical care," she says.

When a newborn has been exposed to illegal drugs or when the mother of a newborn has had her rights to other children terminated, Zielinski calls in children's protective services to review the situation and determine if it's safe for the baby to go home with the mother.

Last year, she called in children's protective services a total of 79 times out of about 1,800 patients admitted to her units. "I always evaluate the situation to confirm the information we receive. I try to be as nonthreatening as possible. I congratulate the mother on the birth of the baby, check with the nurse to see if the mother and infant are bonding and if the mother is providing appropriate care," she says.

Zielinski asks the mother about the home situation and what kind of preparations have been made for the baby and prepares them for the children's protective services evaluation.

"The mothers are often frightened that their baby will be taken away. I can't give them any assurances but I provide as much support as possible. I explain to the mother that our job as a hospital is to provide the best medical care and that we are required by the law to notify children's protective services but that doesn't change the care she or her baby will receive," she says.

Zielinski encourages the mother to contact a family member or friend for support.

"When children's protective services is going to court to get custody of the infant, it's stressful for the mother. I try to provide as much support as possible but they don't see me as the supportive party," she says.

Nursing staff play support role

The nursing staff also play a supportive role, encouraging the mother to talk with the children's protective services worker.

If there is a court hearing, Zielinski arranges transportation for the mother to make sure she can attend if a family member isn't available to take her.

"If a baby is removed from the mother's care and she comes back to the hospital to say goodbye to her baby, it's an emotionally tense situation. In these cases, a lot of my work is to try to diffuse the emotions," she says.

Zielinski collaborates with adoption agencies and adopting families when women make a decision to place their babies for adoption.

"We are a neutral party and we help the birth mother with whatever plan she decides on. If she changes her mind about the adoption, we assist her in making alternate arrangements," she says.

If she discovers patients who are at high risk for postpartum depression, she recommends a psychiatric consultation and provides resources for ongoing treatment.

"We want the patient to set up an appointment before they leave the hospital," she says.

As they go about teaching during the pregnancy and delivery, the nursing staff notice if the patient exhibits signs and symptoms of postpartum depression, she adds.

"The OB/GYNs are very sensitized to the likelihood of postpartum depression and they screen their patients very carefully," Zielinski says.

*(For more information, contact **Barbara Zielinski,** MSW, CCM, Ingham Regional Medical Center, Lansing, MI; e-mail: barbara.zielinski@irmc.org.)* ■

Advance directives issued in nationwide campaign

Aging with Dignity, the United Health Foundation, the American Hospital Association, and other national and local organizations will distribute 500,000 advance directives in the coming year in a campaign to help patients and families make important advance decisions about end-of-life care.

The "Five Wishes" directive, available in 20 languages, addresses an individual's medical, personal, emotional, and spiritual needs before a health care crisis. It is recognized as a legal and binding document in 40 states and used as a model to prepare directives in the other 10.

"The conversations need to be with families, so at the end of life, families are not torn apart," **Ruth Sullivan**, president-elect of the Society for Healthcare Consumer Advocacy and director of patient and family advocacy for Shore Health System in eastern Maryland, said recently at a briefing on the campaign.

Copies of the translated Five Wishes documents were to be sent at the end of June to all U.S. hospitals, as well as to consumer advocates and volunteers. More information on the campaign is available at www.agingwithdignity.org. ■

(Continued from page 118)

ters by participating in scenario-based planning exercises, says **Nathan Szenjniuk**, a member of the Center for Healthcare Emergency Response, based in Nashville, TN.

Disaster planning is more than just drafting agreements and letters of understanding and putting them in a large book of complicated plans that nobody will have time to read when a disaster strikes, Szenjniuk asserts.

Decision making during a disaster

A lot of the work in a disaster goes into decision making, and people have to have an understanding of what they need to do, he adds.

"The real planning for a disaster occurs when the staff take the time to look at every single scenario that could happen and what the hospital's response will be. It all gets down to what you are going to do to get your patients out of the hospital safely. When you consider that it took nearly 44 hours to evacuate a hospital that was flooded during Hurricane Allison, you can see that having a system in advance of need is critical," Szenjniuk says.

He encourages case managers to meet with the physicians on their unit and the hospital's disaster planner periodically to discuss hypothetical situations in which patients may need to be moved and to brainstorm on ways to get patients safely out of the hospital and to another venue of care.

Look at the potential scenarios and determine what you need to do to keep your patients safe and what capabilities your hospital has to do so, he adds. Then, come up with where you can get the resources you don't have and develop a contingency plan. For instance, if you are a case manager in a 20-bed neonatal unit, know what other resources are available for your patients in case the hospital has to be evacuated. This means finding out what hospitals in the state have neonatal units, determining how long it will take to get your patients transferred there, and knowing what resources, such as ambulances and nurses, will be needed in order to transfer the patients safely, Szenjniuk says.

"What hospitals really need are simple planning matrixes that show how many hospitals there are in the state, what capacity each has for each kind of patient, travel distance, and travel time to each. This matrix can be used as simple planning tool," he says.

Think about how many people and what kind of resources will be needed to evacuate patients in case of a disaster. Look at where they can be moved, how they will be transported, and how long it will take. Determine who will coordinate the move, who will make the calls to facilitate transporting the patients, and who they will call.

Szenjniuk suggests developing a scenario and doing a trial run with a volunteer.

For instance, the scenario may be that the city is experiencing major flooding and water is already six feet high on the first floor of the hospital. How do you get an ICU patient to safety?

Look at what equipment such as portable ventilators will be needed, what kind of transportation will be necessary, and how you will get the patient to the transportation.

As an exercise, tape all of the equipment the typical ICU patient needs onto a volunteer and see what it takes and how long to move him to a place where he can be transported to safety. Suppose you have a patient who just had a laminectomy and has to remain immobile. Think about how you would transport him or her out of the hospital.

"Case managers should talk with physicians about how certain types of patients can be safely moved. Ask if someone who has to remain immobile would be better off being moved in a helicopter vs. a boat. Get the physician's first choice, second choice, etc. If Option 1 is not available, decide whether the physician has to be around to determine what Option 2 would be," Szenjniuk says.

Determine what your hospital's capabilities are for caring for the patients and where you will get whatever resources may be needed. "Capability-based planning is critical. It cannot be done in a vacuum. Everyone in the hospital has to work as a team with the hospital disaster planner who will interact with the county emergency planner," he says.

Hospital disaster planning is a dynamic process because the hospital has a different population with different needs every day. "You can't just make a disaster plan today and look at it again in 30 days," Szenjniuk says.

When case managers and physicians meet with the hospital's disaster planner, they should explore ways to tie critical disaster planning information to the medical record, starting with the preadmission orders, he says. "A disaster evacuation or disaster discharge plan needs to be part of the admissions process. Hospitals need to have a patient evacuation and tracking form within their admissions software and electronic medical records. Thinking

about evacuation from the beginning is the only way to understand its impact on any given day," Szenjniuk adds.

Case management directors should encourage their staff to think beyond their day-to-day care of patients and keep in mind a contingency plan for every patient in case the hospital has to be evacuated, he suggests.

As soon as patients are admitted, case managers should keep in mind what would happen to the patient in the event of a disaster.

"The real issue is contingency planning. Plan in such a way as to know who you would use to move the patient safely if necessary," Szenjniuk says. ■

ACCESS MANAGEMENT QUARTERLY

Costly errors are common in same-day surgery arena

Preadmission coordinator a must, consultant says

Mistakes involving patient classification and preauthorization of procedures are among a lengthy list of common errors made in the same-day surgery arena, says **Bob Whipple**, RNC, CCM, CCS, MHA, a Boston-based senior management consultant with ACS Healthcare Solutions, who specializes in all areas of the revenue cycle.

Those errors, Whipple adds, can cost hospitals thousands of dollars in denied claims, as well as cause them to lose business to a growing number of freestanding surgical centers.

With regard to obtaining authorization for the surgery, he says, "sometimes the hospital gets it, and sometimes the physician's office gets it. If they pre-certed for an inpatient, and you did it for an outpatient, the bill is denied.

"People who schedule for physician offices don't know the first thing about coding," he points out. "They will send a sheet that says 'possible kidney transplant,' and that's not a diagnosis."

When those orders get to bed placement, Whipple says, "it's crucial that someone with clinical case management skills — preferably a registered nurse — is on hand to make sure everyone who's going into a bed is at the right level of care."

The designation should be "inpatient" or "outpatient," but not "observation," he says. His experience, adds Whipple, is that a lot of hospitals make the mistake of pre-certing a same-day surgery patient under the observation designation.

"It's a big compliance issue," he notes. "How do you know they will have to observe somebody after surgery? You don't have a crystal ball."

A patient cannot be put in observation status preoperatively, Whipple emphasizes. "Postoperatively, you could think about it, but I wouldn't recommend it. Same-day surgery comes with an implied 24-hour length of stay, so the designation either should stay 'same day,' and the person should be discharged and go home, or if necessary, the patient should be converted to inpatient status."

These mistakes happen with the observation designation because people don't understand what it really means, he says. "The physician thinks, 'I want to observe the patient,' [so that must be the right classification]."

With Medicare, there are many CPT (common procedural terminology) codes that are for inpatient-only procedures, Whipple adds. "If a procedure happens to be on the inpatient-only list and the patient receiving that procedure doesn't have inpatient status", he says, "[Medicare] will deny the claim and you can't even appeal it. It's a technical denial."

There are hospitals doing mastectomies, laminectomies, and thyroidectomies — all inpatient procedures under Medicare — on an outpatient basis, and when the bills for those surgeries are denied, there is no recourse, Whipple points out. "What Medicare is trying to say is, 'We want our patients to be [admitted to the hospital] for these kinds of procedures.'"

This kind of occurrence is "very common," he adds. "I find it everywhere I go."

Again, the take-home message is that there

needs to be a clinically trained person — within the access department — who literally reviews every patient before he or she is placed in a bed for outpatient surgery, he emphasizes. "You can't expect office staff to do it. They will put patients in a bed with wrong orders or no orders."

One of the other costly errors that hospitals are prone to make in their same-day surgery operations has to do with cardiac interventions, such as cardiac catheterizations, Whipple says. The Medicare reimbursement rate for cardiac caths is about $5,000, he adds, but if the physician ends up putting in a stint as well, the procedure — known as angioplasty — goes in the inpatient category, and reimbursement is about $19,000.

Therefore, if the change in patient classification is not made and the surgery is billed as an outpatient procedure, Whipple notes, the hospital loses $14,000.

"When I'm doing revenue cycle assessments, these are areas where [hospitals] fall down all the time," he says. "I almost always find it with angioplasties."

Other mistakes that are frequently made in same-day surgery settings include the following, Whipple says:

- Developing a process that is organized around the hospital staff and not the patient, specifically as it relates to same-day work-up and surgery.
- Not gaining cooperation from ancillary departments to facilitate and support same-day services.
- Not changing surgical scheduling processes to support same-day services.
- Not ensuring preregistration for all same-day patients, including preauthorization/precertification and estimation of copays for collection at time of service.

Coordinator 'should report to access'

The clinically trained individual — sometimes called a preadmission coordinator — charged with making sure patients and procedures are properly designated should report to patient access leadership and should serve as the clinical liaison for the entire department, Whipple contends. "If you don't have that position filled, you are losing a lot of money."

In fact, all areas that perform functions that are part of the revenue cycle ultimately should report to the CFO, he says. "Sometimes hospitals have the bed board report to nursing, or have some sort of precert department or a transfer center

CE *questions*

5. When Hurricane Rita appeared to be heading toward Dallas in 2005, case managers at Medical City Dallas gave every patient in the hospital a numerical assignment according to his or her readiness to be discharged. What did an assignment of four mean?
A. Patient can be discharged immediately.
B. Patient can be discharged to a lower level of care.
C. Patient can be discharged home with home health.
D. Patient cannot be discharged under any circumstances.

6. At McLaren Regional Medical Center in Flint, MI, how many units do the social workers cover?
A. two units each
B. one unit each
C. three units each
D. the hospital doesn't have social workers

7. As hurricane season approaches case managers in North Broward Hospital District's disease management program make sure eligible patients are signed up for community and medical shelters. What group receives priority?
A. Those who are most medically fragile.
B. Those with multiple comorbidities.
C. Those who live in mobile homes.
D. Those who live nearest to the ocean.

8. According to Nathan Szenjiuk, a member of the Center for Healthcare Emergency Response, Hurricane Allison flooded one hospital, it took how long for all patients to be evacuated?
A. 44 hours
B. 24 hours
C. 18 hours
D. 12 hours

Answer key: 5. D; 6. A; 7. D; 8. A.

CE instructions

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

that works on its own in another location. [Access leadership] needs to understand all points of entry and make sure to have control over all of those areas."

Whipple recommends that access management work with marketing to create a patient satisfaction survey for the same-day surgery area, and use the results to make improvements and to provide feedback to staff.

General satisfaction surveys, such as those conducted by Press Ganey, aren't specific enough to meet that need, says Whipple, who suggests asking questions geared toward the outpatient experience: "Was it easy to get an appointment? Was the phone answered promptly? Do you feel you were given answers in a timely manner?"

Leverage as much technology as possible to keep customers satisfied, he advises, including providing on-line registration and implementing kiosks to allow service area check-in with electronic signature and payment of copays and deductibles.

Whipple suggests these benchmarks for the same-day surgery operation:

- Wait times for outpatient registration — less than 10 minutes.
- Registration data accuracy — greater than 98%.
- Abandon call rate in scheduling — less than 2%.
- Scheduling calls per day — greater than 95.
- Scheduling quality — greater than 98%.
- Average time to place in a bed — less than 10 minutes.
- Registrations/preregistrations per hour by representative — greater than six.
- Quick check-ins per hour by representative — greater than 12.
- Precertification at 100%.
- Point of service collections — greater than (your hospital's numbers).
- Patient satisfaction score — greater than 95% per reporting period.
- 100% auditing of Medicare Secondary Payer questionnaire.
- Operating room cancellations — zero cases.

Freestanding centers an issue

One of the challenges hospitals face in regard to their same-day surgery operation is the competition posed by freestanding surgical centers, which tend to cherry-pick the easiest and most lucrative cases, Whipple notes.

If you're a patient access manager and a freestanding surgical center has opened down the street from your hospital, he advises collecting data to determine if your operation is being affected.

"Look to see if your volume is down and at the referral patterns of your physicians," Whipple says. "Then you are prepared to go to senior management and say, 'We've got a problem. Dr. Smith is referring patients [to the freestanding center].'"

To address this issue, it takes a lot of support from senior management, Whipple adds. "You need a chief medical officer who understands the problem — why that is a bad thing. It's happening more and more places."

(Editor's note: Bob Whipple can be reached at Bob.Whipple@acs-hcs.com.) ■

Putting nurses in access results in financial gains

'It's easy to show ROI'

Adding six nurses to the central scheduling department has dramatically reduced both denied claims and accounts receivable (AR) days at Delnor Community Hospital in Geneva, IL, says **Karin Podolski**, RN, MSN, MPH, CHAM, director of patient access.

Having nurses check physician orders for completion and take verbal changes for orders over the phone, as well as serve as a resource for other access employees, has led to improved relations with physicians and with other hospital departments, Podolski adds.

The program began in 2004, she explains, as a result of multiple complaints from clinical areas based on scheduling quality.

"We would book an exam, and the patient would arrive and it would be the wrong exam, or there would be a problem with the order and we couldn't reach the physician, so we would have to reschedule," Podolski says.

Now when a patient walks in with an order, registrars check it, but nurses are there as a resource, she says. They can amend orders with unacceptable abbreviations — such as an up arrow for increase or HTN for hypertension, Podolski adds.

"We have a lot of illegible orders, and [nurses] can call the physician's office and take the verbal

change for the order," she says. "We use them to check Medicare orders for medical necessity. The nurse reviews the patient history to clarify whether the person has a [particular condition], and then can take a verbal amending of the order over the phone."

In the past, patient accounts staff would attempt to contact physicians by fax for further diagnoses, which the physicians didn't like, she adds.

"Say a patient is sick, and calls the physician who is on call on Saturday morning," Podolski says. "If the physician is at home or in the car and wants to send the patient over for an exam, [he or she] can just call [the hospital] and send the patient over with a verbal order."

Nurses trained in coding

Delnor's access nurses were hired either from physician offices or other outpatient settings such as same-day surgery, she notes, and received about two months of training in outpatient coding.

The investment has more than paid off, Podolski says. "We reduced our medical necessity write-off from 10% to 0.6%." During the same period, AR days have gone from the high 70s to 40, she adds. "It's easy to show return on investment."

Previously, Podolski says, "there were stacks of orders without diagnoses or that [staff] couldn't read so they couldn't code." Now the majority of the coding is done on the front end, with some completed on the back end, she adds, but it's all under the purview of the access department.

The original goal was to reduce the medical necessity write-off from about $11 million to about $3 million, she says, but the figure is now down to about $600,000.

"The only thing we really write off now is from the emergency department," Podolski adds. "It's virtually zero in the other areas. We don't intervene with the ED physicians too much because that's a hard area to address."

If an elderly patient falls, for example, the protocol is typically to do a CAT scan of the head, she says. "We can't really prove they fell and hit their head often because they are unable to communicate clearly, but [doing the scan] is good medicine."

Her own nursing background makes her particularly sensitive to ensuring that the department's nurses are kept "in the nursing loop" within the hospital and the nursing community at large, Podolski says.

"Last year, I had them give education to the entire [700-member] hospital nursing staff as part of spring nursing education," she adds. "There were six sessions where they talked about medical necessity, patient orders, and diagnoses. We do get orders from the ED and from the patient floor, so it's valuable to speak to those nurses so they know what is required."

Podolski says she also makes sure that access nurses participate in the nursing week celebration each May and in the shared decision-making opportunities for nurses within the hospital, such as committees on professional practice.

With hospital nurses typically limited to a 7 a.m. to 3:30 p.m. schedule, or a shift that begins at 11:30 p.m., the more flexible hours offered by the access position make it an attractive option, she points out. "We have a variety of staggered hours. I let them set their own schedules as long as the department is covered, with a nurse available in both the scheduling and medical necessity areas."

The access department hours are 7:30 a.m. to 6:30 p.m. Monday through Friday and 9 a.m. to 1 p.m. Saturday, Podolski says.

When hiring nurses for the access department,

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

- ■ Facilitating communication between disciplines
- ■ Why patient throughput is such important issue
- ■ Helping chronically ill patients stay out of the hospital
- ■ How to prove the value of case management
- ■ Strategies for complying with the transfer rule

Podolski says, she looks for individuals with leadership traits. "They're running the show in problem solving, and they're also a resource for the rest of the access staff who may not be [clinically] trained."

Before registration staff call a physician's office, she says, "I try to have them filter it through a nurse, so they're not calling all the time."

Having nurses in her department, Podolski says, "has built within the hospital a reputation that we do have resources and we do have credentialed staff within access. If issues arise with clinical areas, they are very responsive when a nurse calls them."

Delnor is a magnet nursing hospital, she notes, and having the nursing component in access has contributed to that process. "It provides opportunities for nursing to grow and expand its role, which is important for magnet credentialing."

As part of their job, the access nurses visit physician offices, Podolski says, to build relationships with physicians and their staffs and to provide them with medical necessity tools. The frequency of the visits varies, but they are typically made twice a month, she adds.

"We give them access to software to check medical necessity, and we give them copies of local coverage determinations and updates on regulatory changes, like changes in Medicare guidelines."

(Editor's note: Karin Podolski can be reached at karin.podolski@delnor.com.) ■