HOSPITAL CASE MANAGEMENT™

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

AHC Media LLC

IN THIS ISSUE

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Case manager-physician collaboration essential for good patient care

Effective communication ensures a good working relationship

When it comes to talking with physicians about documentation or admissions criteria, it's often not what you say but how you say it that helps you get an answer.

Consider this: Which would you rather hear?

"You can't admit Mrs. Jones. She doesn't meet admission criteria."

Or, "I see you're admitting Mrs. Jones. Do you think she could go home if we arrange for home health services?"

Case managers must develop effective communication skills so they don't approach physicians in a way that suggests they are telling the doctors how to practice, says **Jane Reed**, RN, CCM, director of care management at Berkshire Medical Center in Pittsfield, MA.

"You'll get further if you work collaboratively with the physician. For example, ask the physician's opinion regarding what is going on with his or her patient, rather than telling them what they have to do. Otherwise, they may feel like they're being strong-armed, and no one likes that," adds **Doris Imperati**, BSN, MHSA, CCM, managing consultant for Navigant Consulting, a consulting firm with headquarters in Chicago.

A former case manager and case management director, Imperati works with hospitals for six months at a time, helping staff implement clinical documentation improvement programs and working side by side with the clinical documentation specialists as a colleague and mentor until they achieve the skills they need to work independently.

Rather than telling a physician a patient has met his length of stay and has to be discharged, ask, "Could you help me understand why you're keeping the patient here so I can communicate relevant clinical information to his insurance company?" she advises.

"The physician may have insight into the case that others do not, such as knowing that the patient isn't clinically ready for discharge or that there's a sick family member at home, or something else that may not be

indicated in the chart," she says.

Keep in mind that physicians are concerned about caring for their patients and don't understand the twists and nuances of what each payer covers and doesn't cover, Reed suggests.

"Each patient's care has to be tailored to that patient's needs and the physicians know their patients. Case managers have to listen to what the physicians are saying when we query them. We have to be conscientious about cost but we also must do what's best for the patient," she explains.

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"Case managers and utilization review nurses are hired because they are competent and confident and are effective because they take initiative, but sometimes they need to be cautioned about coming across as arrogant or condescending to the physician," says **Steve Blau**, MBA, MSW, LCSW-C, director of case management for Good Samaritan Hospital in Baltimore.

Good Samaritan Hospital began a program to improve collaboration with physicians five years ago. "We knew we couldn't control physician behavior but we could change ours. Some of the things we were doing were sabotaging our outcomes, by not being prepared or not having complete information when we called the physicians," he says.

The case management team started by determining what kind of relationship it wanted to develop with the medical staff, by identifying goals, and by defining what would determine that that improvement had occurred.

"We had to look at what we could do so physicians' experience with us would be positive. We wanted them to see us as being helpful and helping them achieve their outcomes," Blau says.

The case management team and the physician advisors attended quarterly staff meetings and department meetings and told the physicians their goals and what they were doing to meet them, asking them for help in achieving the goals.

"We're pushing them to think about organizing their day around what we see as priorities. They may not like that but we want to them to see us as being engaged in helping them achieve their outcomes," Blau says.

Getting physicians to listen often just involves using basic communication skills, **Peter Moran**, RN, C, BSN, MS, CCM, points out. Moran, a case manager at Massachusetts General Hospital, is the first hospital-based staff case manager to serve as president of the Case Management Society of America (CMSA).

"If physicians feel that case managers are there to assist them, they're more apt to respond. A lot of time, it's a matter of showing physicians that you can help them deal with a difficult case, rather than that you're telling them what to do," he adds.

If you feel a patient is ready to go home and the physician disagrees, ask if there is something you can do to address his or her concerns, such as sending the patient home and having a nurse see him or her the next day, Moran suggests.

Hospital-based case managers should get to

know the physicians with whom they work and figure out the best way to communicate with them on an individual basis, Moran advises. Don't expect to come up with a one-size-fits-all strategy, he adds.

In some instances, the physician may prefer for you to talk to the nurse practitioner or physician assistant on his or her team. Some prefer e-mails; others prefer to set up a time to speak with you by telephone.

Once you get to know the doctors, understand what makes them tick and use that to build a relationship with both personal as well as professional aspects. Ask to see a picture of their new baby or where they went on vacation, Imperati suggests.

"Talk to the doctors when you see them on the floor. Take two minutes to build a relationship and let them know that you're not just going to be a nag but that you care about them as a person," she says.

When Imperati approaches physicians she doesn't know, she introduces herself, explains what her role is, tells them the name of the patient about whom she's inquiring and asks whether the patient still is in the hospital or discharged, and then asks for a few minutes of their time.

Recognize what else is going on with physicians when you talk to them, what type of mood they are in, if they appear rushed, if they are focused on a critical patient and then approach them accordingly, Imperati suggests.

"They may have a patient crashing or a backlog of calls to make and you're asking them to drop everything and talk to them," she points out. "Respect them and let them know that you recognize that you're interrupting their important work to do your work. If the physician seems to be pressed for time, offer to talk at a time when it would be more convenient for them," she adds.

Write out a script of what you're going to say ahead of time so you won't ramble, and aim for a straightforward discussion, not a fragmented conversation, Blau advises.

At Good Samaritan Hospital, the case managers consider what they are going to ask or say to the physician and may even practice with the physician advisor before calling the physician.

"Case managers need to think about their word choice and how they approach the physician," Blau says.

To keep her communication with physicians focused and on target, Imperati jots down a few phrases before approaching the physician, including which patient she's calling about, why she's calling, what the issue is, what she expects the doctor to do about it, and how quickly she needs the physician's intervention to occur.

If it's a telephone conversation and she needs the physician to change documentation in the chart, Imperati asks where and when the doctor wants to meet to resolve the issue.

"I keep it short. They don't want to spend time with me. They want to spend it with their patients and families," she says.

Sometimes the implication of what a physician documents in the chart is clear to the residents, the nurses, and the case managers, but it's not always clear in terms of language that can be coded, Imperati points out.

When CMs see a problem

"Nurses and case managers can look at the abnormal laboratory values documented in the progress notes and know that the patient is in acute renal failure but nowhere is 'acute renal failure' written on the chart. When I speak with a doctor I say, 'The BUN is elevated and the creatinine is elevated. Do you think the patient is in acute or chronic renal failure or is there some other condition causing these abnormal lab values?' I let them know that they're the experts and it's their patient," she says.

Imperati worked with a surgeon who frequently wrote "cherry red urine" on the chart and resisted writing "hematuria."

"We can't code 'cherry red urine,' but it gives a vivid picture of what is going on with the patient. 'Hematuria' doesn't indicate if the urine is dark red or clear with flecks of blood, but it has to be worded that way on the chart or we can't code it," Imperati says.

She explained to the physician that her job was to interpret what the doctors document into a language that the coders could code. The physician agreed to write "cherry red urine — hematuria" on the chart.

Many physicians don't realize that a patient must meet admission criteria specific for each condition as outlined in a reference book and that the patient should not be admitted unless those criteria have been met, Imperati says.

Meeting admission criteria

"They don't want to read the book, but it is sometimes helpful to open it to the page and ask if they see anything that you can use to show that

the patient meets admission criteria," she says.

When it comes to documentation issues, pull out a resource book and show the physician how documentation can change things, she adds.

For instance, show him or her that without the complication/comorbidity (CC) the length of stay should be 3.2 days but when a CC is documented it allows the patient to stay for 4.8 days.

When inpatient criteria aren't met

When patients don't meet inpatient criteria, Moran reviews the available information, and then speaks with the patient and family to see what happened that brought them to the emergency department.

"I then share with the physicians what I learned and ask if there is a reason they are admitting the patient. I ask if they think the patient's needs might be met in a lesser level of care. It is my experience that if I can come up with a reasonable alternative to admission, physicians will listen as long as their concerns are addressed," Moran says.

When she was a case management director, Imperati spent five minutes during every physician staff meeting to educate the physicians on admission criteria, transfer criteria, community resources that patients could access rather than being admitted, and other issues that case managers encounter.

"Now that we have switched to the new MS-DRG system for reimbursement, I am spending a lot of time getting physicians up to speed on the new system. I go to the physician meetings, the specialty meetings, or drop by the physician offices and spend a few minutes giving them little snippets of information," she says. ■

Point out problems, then let go of them

Don't feel like you own the issue

It's frustrating when you point out that a patient doesn't meet acute care criteria or that documentation in a chart is not complete and nothing happens, even if you take it to your physician advisor.

Don't take it to heart. Move on to the next case and hope it turns out better, advises **Peter Moran**, RN, C, BSN, MS, CCM, emergency department case manager at Massachusetts General Hospital and president of the Case Management Society of America.

"I don't keep focusing on these cases. If I lose, it's not the end of the world. I look at it as making progress toward the next one," he says.

Start with the positive

At Good Samaritan Hospital, **Steve Blau**, MBA, MSW, LCSW-C, starts off every case management department meeting and every huddle with a success story to remind the staff of collaborative efforts that do work. Blau is director of case management for the Baltimore-based hospital.

Examples include when a physician came back to the hospital to write a discharge order or stepped up and worked with the case manager to expedite an appeal.

"Case managers and utilization review nurses have the job of identifying problems. If they do that long enough, they start to think nothing is going well and it wears on people over time. If a case manager is having a frustrating day, it's nice to hear that things do go right," Blau says.

The case managers write thank-you notes to physicians, nurses, therapists, and leaders who have been helpful in documentation or throughput issues.

Don't take full blame

Case managers get frustrated but they must understand that there comes a point when they have done all that they can do, Moran says.

"We don't own full responsibility for length of stay or patient admissions. We're responsible for reviewing information, trying to influence practice patterns, problem solving collecting data, and bringing problems to the attention of the administration. Once they have the information, it's out of our hands," Moran says.

Case managers are sometimes all too eager to take on full responsibility by applying admission criteria and saying the patient can or can't be admitted, Moran points out. "We're part of the team. We raise the questions, get the data, and when we bring it to the physician advisor, then it's their responsibility," Moran says.

Remember that admission criteria aren't necessarily black and white. "Guidelines look at severity of illness, intensity of services, but it is important to remember all of them also have a discharge criteria screen and one of the criteria looks at whether the

patient is safe at discharge," Moran says.

When Moran completes an assessment on a patient in the emergency department who does not meet criteria, he contacts the physician, asks what his or her concerns are and how they can work together to resolve the issue.

"I go to the physician advisor when I can't get answers and I am at the point when there's nothing more I can do. If the physician advisor gets involved, it's great. If not, that's their decision and I let it go," he says.

Document clearly what is going on, Moran advises. For instance, you may think the patient needs a skilled level of care but can't get insurance authorization until Monday or you may not be able to find an appropriate bed.

Document all the options you explored, such as there were family members who could take the patient home, so it doesn't appear that someone who didn't meet criteria was admitted and nothing was done to try and avoid the admission, Moran says. ■

Five tips for better CM, physician collaboration

Remember that the case manager-physician relationship is like a marriage and you have to keep working at it to make it a good one, says **Steve Blau**, MBA, MSW, LCSW-C, director of case management for Good Samaritan Hospital in Baltimore.

1. Share your successes with physicians. Give them outcomes data and thank them when they have helped you do your job.

2. Never talk to a physician about money. Talk about quality of care, suggests **Doris Imperati**, BSN, MHSA, CCM, managing consultant for Navigant Consulting, a consulting firm with headquarters in Chicago.

3. Let the physician know that documentation will record the quality of care so the public report cards will accurately reflect how sick the patient really was and how successful the hospital was in treating those cases, she says.

"I try to explain that the government regulations will impact on the patient. It's not that the physicians aren't giving quality care; but if it isn't documented, it can't be measured," she says.

4. Try to talk to the physician face to face whenever possible. It's easier that way for them to understand your concerns, advises **Peter Moran**, RN, C, BSN, MS, CCM, emergency department case manager at Massachusetts General Hospital in Boston.

"If case managers are unit-based, it's somewhat easy to find the physicians when they are on the floor. If they are service-based, it gets tough but there's no substitute for face-to-face communication," he says.

5. Be concise and specific and make sure the timing is right when you query the physician, Imperati suggests.

"A physician's time is very precious. The time they're spending with me is time they're not spending with their patients and families," she says.

Always tell the physician, "If you don't agree with me, don't document it," Imperati says. ■

Documentation review plan ups reimbursement

Collaboration among CM, coders, physicians key

A clinical documentation review program at Jupiter (FL) Medical Center increased Medicare reimbursement by $278,000 the first year for the 156-bed community hospital.

"The crux of our success was the excellent working relationship that case management has with the medical records staff, the coders, and the physicians. If we miss something and the coders pick it up, they call us and educate us, and we in turn educate the physicians," says **Cathy J. Hamilton**, RN, BA, MHS, CPHQ, CPUR, director of case management.

Case managers at Jupiter Medical Center are unit-based and cover the emergency department and the intensive care unit as well as the medical, surgical, and telemetry units. A case manager is on duty in the emergency department from 6 p.m. to midnight. The case management department is piloting a physician group model on the telemetry unit.

The medical center began its clinical documentation program by contracting with William Haik, MD, director of Fort Walton Beach, FL-based DRG Review Inc., to conduct an educational session for the case management staff and medical staff on the importance of coding and appropriate documentation to reflect the severity of illness

and intensity of services and its effect on reimbursement and physician profiling. The physician-directed consulting firm specializes in coding guidelines and documentation issues.

After the initial educational program, the case management department developed its clinical documentation review program and created two new positions for clinical documentation specialists, which were filled by experienced case managers.

"I wanted all the case managers to have a general understanding of documentation, but case managers have so many duties that adding something else on top of them was not feasible. I also felt that we needed staff who specialized in clinical documentation review," Hamilton says.

One of the clinical documentation specialists had been on the hospital staff for 25 years and had a longtime relationship with many of the physicians. This relationship helped when staff began querying physicians.

Preparing for the MS-DRGs

As news came out about the new MS-DRG system, the case management team started preparing the physicians for the changes in documentation they were going to have to make when the new system went into effect Oct. 1, 2007.

"We were doing really well with the program and everything changed. Now we're working on getting everybody accustomed to the requirements for the new MS-DRG system," Hamilton reports.

At first, the case management team concentrated on the 50 or so physicians who comprise the majority of admissions to the hospital and started explaining the new system.

The hospital brought Haik back in the summer of 2007 to address the changes that the Centers for Medicare & Medicaid Services had proposed and to prepare staff for the need for more detailed documentation.

"Dr. Haik educated the physicians that their documentation was going to have to change and let them know that the clinical documentation specialists would be querying them more frequently because of the new documentation requirements," Hamilton explains.

Software helps determine appropriate severity

The clinical documentation specialists use a software program that helps them identify what complications/comorbidities (CCs) and major complications/comorbidities (MCCs) the patient may have and where more documentation may be needed. They enter the patient diagnoses into the program, which asks about comorbid conditions, and then determines which MS-DRG is appropriate.

"Specificity has become more important with the new MS-DRGs. It used to be that heart failure would automatically count as a CC, but now it has to be very specific. We're not a teaching facility, so our physicians don't usually document to that degree; but we're educating them on the language they need to use," Hamilton says.

The clinical documentation specialists review the charts every day to assure that the severity of illness and intensity of services being utilized are adequately documented and for compliance with core measures. They spend their entire day on documentation review and core measures, except on the rare occasion when they are needed to fill in for another case manager.

Before beginning the documentation improvement initiative, the clinical documentation specialists reviewed the hospital's high-volume diagnoses and determined which of them were at risk for under- or overdocumentation. Then they began working with the medical staff to improve documentation. The clinical documentation specialists started out with the 20 DRGs that were the highest volume and most likely to have complications and comorbidities.

Every DRG admission reviewed

"We found that as the documentation continued to improve, we could review additional DRGs. Now we look at almost every DRG admission to the hospital," Hamilton says.

The clinical documentation specialists perform the majority of their reviews in the electronic medical record. If they need additional information, such as information in the progress notes, they can go to the floor and look at the patient charts.

When they observe a problem with the documentation, they talk to the physician on the floor or leave a written query. The case managers have a good working relationship with the physicians and their office staffs, which helps in the documentation process, Hamilton says.

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CRITICAL PATH NETWORK™

Multidisciplinary efforts cut LOS, reduce readmissions

CMs move patients to appropriate level of care

At New York Hospital Queens, a series of multidisciplinary, hospitalwide initiatives helped the hospital cut its length of stay by almost a day, despite an increase in the number of patients.

"We are always looking to be more efficient and looking at ways to move the patient to the appropriate level of care, whether it's subacute, acute rehab, or home care," says **Caroline Keane**, director of case management and social work.

At the same time, the case management department examines the cases of patients who are readmitted within 31 days to determine the reasons for readmission and develop ways to avoid them.

LOS ongoing challenge

"We've always tackled length of stay. It's ongoing and involves everything from how we render care to how we move patients in and out of the hospital. This isn't solely about the case management department. Our efforts touched a lot of departments and enabled everyone to look at what they were doing and make improvements," Keane says.

At New York Hospital Queens, case managers are assigned by floor, with one to two case managers on any given floor, based on patient census. The hospital has increased coverage by case managers and social workers. Both disciplines cover the hospital from 7 a.m. to 8 p.m. and on weekends.

Case managers track avoidable days and enter them on a delay report. The multidisciplinary team analyzes the reports and looks for trends.

"We look at admissions, based on concurrent chart review, identify the reason for the delay, and look for opportunities for improvement," Keane says.

Keane meets with the department heads monthly to discuss their delay reports and address the issues.

"The case managers don't interfere in departmental work. We look at what we think the opportunities are," she says. For instance, the case managers work to get tests completed earlier and lab results and other reports out faster.

"A very big piece of lowering length of stay is getting patients ready for discharge. Many of our patients have very complex conditions and we can't push them out so fast that they're going to fail. We work together to figure out what their needs are and make sure they are met after discharge," she says.

Early discharge plans

Case managers at New York Hospital Queens make sure they establish the right discharge plans as early as possible. They assess and reassess throughout the stay and orchestrate the discharge plan.

The case management department uses a computerized discharge planning system that allows them to contact post-acute facilities on-line.

"We regularly meet with nursing to talk about discharge issues," she says. The case managers round on the floor with the nurse manager and other members of the treatment team, such as the physical therapist or the dietitian.

"Rounding has helped a tremendous amount in avoiding delays," she says.

At the same time the team was working to shorten lengths of stay, they also looked at hospital readmissions.

Relationship between LOS, readmissions

"If the length of stay drops and patients keep coming back, that's telling you the length of stay is too short. We want to make sure that we discharge the patients in a timely manner but that we don't aggressively push them out before they're ready," she says.

Keane and her team routinely go over the charts of all Medicare patients readmitted within 31 days.

"We make sure we didn't prematurely discharge them based on their medical condition and that we provided them with appropriate services on discharge. We look at the case management discharge plan to determine if it was comprehensive enough and if it impacted the readmission," Keane says. For instance, the team investigates whether the patient might have benefited from home care but didn't receive it. Sometimes the case manager has recommended the most appropriate plan but the patient or family is not in agreement.

"We do a lot of education and re-education about discharge planning," Keane says.

The team rarely finds examples of patients who are readmitted because they were discharged too soon, Keane says. Instead, it's for other reasons, such as that the family didn't agree with or didn't follow the recommendations that the case manager made in the discharge plan.

"We educate patients on what they should do post-discharge but we can't guarantee compliance with the plan," Keane says.

For instance, the case manager may have suggested that the patient go for rehabilitation and the family insisted on taking the patient home.

"The biggest issue is that patients and families are unrealistic as to how they can manage at home. The case managers may recommend placement in a skilled nursing facility or recommend hospice care but the family isn't ready yet," Keane says.

In the case of patients who are readmitted from a nursing home, the problem may be that the nursing home isn't equipped to provide the care that the patient needs or that the patient didn't receive the medications they needed because they were expensive.

If indigent patients can't afford their medication, the hospital provides them with medication and helps them tap into a pharmacy program that provides free or discounted medications. The case managers print out the paperwork necessary for a pharmacy program for the indigent patient and help them fill it out. They refer them to community clinics for follow-up care.

Dealing with indigent patients

"One problem is that the poor don't always know how to advocate for themselves. We try to connect them with community resources that allow them to receive appropriate services, but they often choose not to follow through. Sometimes they do not tell us that they are in need of assistance during their stay. Often they don't let us know they can't afford the medication," Keane says.

The case managers discuss which patients might be appropriate for hospice or palliative care. They look at whether the family structure might have affected the readmission and what steps they could have taken to make sure the post-acute needs of the patients were provided.

"I use the good and bad cases to educate the case managers. I blank out the names in a chart and talk about the circumstances, pointing out the opportunities for improvement. Sometimes we discuss a real case and on occasions, we create them," she says.

For instance, to educate the case managers and social workers on which patients are appropriate for palliative care, Keane called on representatives from a home hospice organization for help.

They worked together to create 10 hypothetical patients and asked the case managers and social workers to determine which are appropriate for hospice care and which are not.

"We bounce ideas off each other and learn from each other," she says. ■

Proactive approach to comply with new IM rules

'Red Alert' notifies nursing of Medicare beneficiaries

Faced with almost 50% of its patient population receiving Medicare benefits, Berkshire Medical Center in Pittsfield, MA, took a proactive approach to comply with the revised Medicare regulation requiring hospitals to give patients the Important Notice from Medicare, informing them of their right to appeal their discharge.

A multidisciplinary committee came up with

several strategies for complying with the requirements including a "Red Alert" sheet in the patient chart that notifies staff the patient is a Medicare beneficiary, and a three-part form containing the Important Message to cut down on the number of copies of the form staff have to make.

"When the process began, we knew that it wasn't something case management could do independently. We knew we needed to work with other parts of the system, including rehabilitation, behavioral health, and the access department," says **Jane Reed**, RN, CCM, director of care management.

Before the new regulations went into effect July 1, 2007, the access department had given patients the Important Message and checked off that the patient had received the document.

"What changed was that we had to review the discharge appeal rights with the patients, make sure they understand their rights, and require them to sign the form," Reed says.

The medical center created a steering committee that met for a few weeks to map out strategy and plan how to implement the new requirements across the continuum. The committee included the rehabilitation director, the behavioral health director, the access director, bed placement manager, associate clinical director, and supervisor for the shifts that occur when case management is not covering the hospital.

"We wanted to have all the right people involved when the requirement started. Issuing the Important Message is not just a responsibility of the access staff and case management; nursing needs to be involved as well," Reed points out.

When the case manager isn't in

One issue the committee tackled was how to make sure that the follow-up Important Message is given to patients when case managers were not in the hospital.

Case managers at Berkshire Medical Center are on duty eight hours a day and seven days a week and are not involved in discharge planning when patients are going home without services. In those cases, the nurses are responsible for the discharge instruction.

"In other cases, the doctor may come in late, when the case manager has left the floor, and the patient doesn't get the letter before discharge. Many of our surgeons are in the operating room all day, come in and discharge the patient in the evening when the case managers have gone for the day," Reed explains.

The committee realized at the beginning that nurses don't automatically know which patients are Medicare beneficiaries because they don't customarily review the face sheet in the chart, which includes information on the payer source.

"We wanted to find a way to make the information that this patient needs to see the Important Message from Medicare documents readily available to anyone who opens the chart," she says.

The team came up with a "Red Alert" notice, a red sheet of paper that goes in the chart, right behind the admissions face sheet, alerting staff that the patient is a Medicare beneficiary and should receive the Important Message documents.

The committee held educational sessions for the unit secretaries and directors to let them know that the Important Message was part of the admissions packet and what their responsibilities are for ensuring that the Centers for Medicare & Medicaid Services (CMS) requirements are followed.

"Because the letters have to be written according to CMS requirements, we were making copies of the copies each time the patient needed to have a new copy of the Important Message. Eventually, we ordered three-part paper forms, which work a lot better for us. We still have to make a copy if the patient stays beyond the intended discharge, but having the three-part forms has made it more efficient," she says.

Tracking delivery, compliance

The hospital set up a system so that once the Important Message is given to a patient, the information is entered into the electronic medical record so the case managers and access staff can see it without having to go into the chart.

The medical record contains the patient name, date of admission, and date the letter is due, allowing Reed to track the information on a daily basis. The case management staff review the daily reports. The access staff input the information into a spreadsheet every month to track compliance.

"Rather than having to go through all the Medicare charts, we set up a system so that the information was in the medical record and available to the case managers and access staff," she says.

The hospital assigned a temporary person on light duty who helps provide the notices, added an FTE utilization review specialist to the case management department to help with

the process, and increased secretarial support for the department.

The medical center's hospitalist group manages a good portion of the medical patients and got involved with making sure patients were expecting their discharge from the beginning.

"Our physicians are doing a phenomenal job of talking with patients and involving them in the discharge," she says.

But some were so proactive in notifying patients of a pending discharge that the patients felt like they weren't ready to go home and chose to appeal.

"The physicians have gotten better in recognizing that we can't give out the Important Message letters too early," she said.

Reed and her committee have met with the hospital's compliance officer and are working on an action plan to improve compliance. "We still have growing pains and are not as compliant as we feel we should be," she says. The hospital is revising its discharge checklist to include the Important Message.

Identifying best practices

During the weekly team meeting, Reed goes over compliance with the Important Message floor by floor, pointing out areas where the compliance is higher, giving the team an opportunity to discuss the best practices.

"We look at whether the document was missed on admission or missed at discharge," she says.

For instance, if a patient is in the emergency department in a crisis situation, the staff are dealing with life or death issues and it would not be appropriate to read the patient their discharge rights, Reed points out.

Now, if the patient doesn't receive the notice on the first day, someone from the access staff goes to the floor and meets with the patient to discuss the document on the second day of the stay. The case manager provides the notice if the patient is slated for discharge before the access staff can meet with him or her.

"We're improving communication. The unit secretary goes over the list of who is anticipated to be discharged that day. If the patient is being discharged and there is a 'Red Alert' page in the chart, the secretary alerts the case manager," she says.

Facilitating the appeals process provided another challenge since the medical center is a 2½-hour drive from the Boston suburb of Waltham where the state's peer review organization (PRO) is located.

Reed and her team looked at setting up a courier service but decided it wouldn't be cost-effective because of the low volume of appeals vs. the cost for bonding a driver.

They ended up sending the appeals materials by overnight mail but, in some cases, it extends the stay for up to four days.

"If the discharge is planned for Friday, the patient has until midnight that day to appeal if they disagree with the plan. If we send it overnight, there's nobody to open the Saturday mail and the PRO has another 24 hours to respond after they see the chart," she points out.

Faxing the documents creates problems because the copies don't always go through clearly, she says.

Another delay occurred when the hospital sent the appeal by overnight mail but it didn't arrive until 1 p.m., and the PRO medical director wasn't available until the next day.

"We have to deal with family dynamics when a patient doesn't meet inpatient criteria but the family doesn't want him placed in a nursing home. There are also people who manipulate the system," Reed says. For instance, the daughter of one patient wasn't ready to take her mother home so she appealed. The PRO upheld the discharge but the woman gained a discharge delay.

"It's a real learning curve," Reed says.

Issuing HINNs

If the PRO notifies the patient that the hospital's decision has been upheld, the hospital can issue a Hospital Issued Notice of Noncoverage (HINN) notifying the patient that he or she is responsible for payment, effective on the next day or 24 hours after the decision is made.

"Keeping all of this straight has been a challenge. We have to keep going back and referencing which letters CMS says we should give out when," Reed says.

The new rules for notifying patients of their rights to appeal their discharge puts more emphasis on involving patients in discharge processes and preparing them to go home, Reed points out.

"As painful as it's been, it's helped place greater emphasis on the discharge process. It's not just the message. It's how we deliver the message. It's not effective to tell a patient they're going home today and surprise them. We should talk to patients about discharge throughout the day so they aren't surprised on the day of discharge," she says. ■

(Continued from page 6)

"The physicians respond to us because we communicate with them concurrently, while the patient is still in the hospital. They were not responding well to post-discharge queries by the coders because the patient was already gone and they had completed that medical record and moved on. We catch them on the floor or concurrently fax information or leave messages with their office," she says.

The clinical documentation specialists frequently call on the coders with questions about documentation.

"The coding staff are the real experts. Every time we meet with them, I am amazed at the extent of their knowledge. We need their help more than ever now with the MS-DRG system," Hamilton says.

Coders, staff meet monthly

The coders meet with the case management team monthly to provide feedback and ask them questions. If the coders determine that there is a problem with the documentation when the medical records department starts working with the chart, they notify the clinical documentation specialist, who contacts the physician.

"If the coders see something that could indicate a CC or an MCC and it's not documented, it could make a huge difference in the reimbursement," Hamilton says.

If the physician typically has patients in the hospital, the clinical documentation specialist asks the case manager on the unit to call her when the physician is in the office and talks with him or her one on one. Otherwise, she faxes the query to the physician's office or calls the physician on the telephone.

Follow up with physician advisor

The case managers and clinical documentation specialists can call on their physician advisor if the physician doesn't respond to a query.

"He doesn't pressure them to give us an answer one way or another. He just asks them to give us an answer and sign the query," Hamilton says.

The case management team has worked to develop a good relationship with the office staffs of the hospital's admitting physicians. The hospital hosts a yearly open house and luncheon for the medical office staff members. The case management department sets up a display at the luncheon, with information on clinical documentation issues, utilization issues, and core measures.

"We give the office staff a list of case managers and their extensions and try to develop a good relationship with them so that when we communicate with them, they'll know who we are and make sure the physician responds to our query," she says.

Continual education

Throughout the year, the case management department continues educating the admitting physicians on the clinical documentation initiative.

Hamilton writes an article on clinical documentation for each issue of the hospital's quarterly physician newsletter.

"We try to keep the subject in front of the physicians all the time," she says.

When the hospital invited Haik to speak to the physicians at their semiannual medical staff meeting, they put him first on the agenda before the business part of the meeting.

Bringing in consultants

Bringing in a physician-directed consulting firm was an effective strategy because it was peer-to-peer communication, Hamilton says.

Haik explained to physicians how documentation can affect their physician profile and how it could affect them personally, Hamilton recalls.

"If the profile makes it appear that a physician is taking care of patients who are not severely ill and it costs a lot to treat those patients, then the insurers may not want that physician on their panel," she says. "The medical staff paid a lot of attention to Dr. Haik because he is a fellow physician."

The physicians could identify with the consultant when he told them he became involved in the coding arena because the clinical outcomes of his severely ill patients were not being accurately reflected and it affected Haik's practice profile, Hamilton says.

"He said he knew that he was a better doctor than his profile indicated. Our physicians could identify with that. Any time you can get physicians to understand how something impacts them personally, you get a lot more buy-in," she says. ■

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Program targets uninsured, underinsured patients

Goal: Establishing 'home' at nearby center

Self-pay emergency department patients who have no primary care provider are being referred to a nearby primary care and specialty center under a program in place at St. Mary's Hospital in Tucson, AZ, part of the Carondelet Health Network.

The majority of the patients involved are uninsured or underinsured working people who may have already applied for help through the Arizona Medicaid program, known as the Arizona Health Care Cost Containment System (AHCCCS), says **Cassandra Pundt**, RN, PEN, emergency services patient representative. "They make a little too much money [to qualify] or have had AHCCCS but haven't kept it up."

The referral "gets them into the loop" to receive primary care services at St. Elizabeth's Health Center, she adds. "Our goal is to get them follow-up care and [do the] paperwork. If they get a health care home, they will use ED services less.

"Our [ED] volumes are overwhelming, especially in the winter," Pundt says. "Once we get into the winter crunch, we can have 20 or 30 people waiting for an ED treatment bed, although they are triaged immediately."

The process, which began in August 2006, works as follows, she explains: "Our [registrar] gets the demographics and data needed for our Meditech [registration and patient logging] system, which logs the patient visit, including the insurance provider if the person has one.

"Our information systems staff have programmed the registration system to spit out the names of patients who meet the criteria — self-pay, no insurance provider," she continues. At 6 a.m. each morning, Pundt says, she receives the report on the previous day's patients.

As of April 2007, there is a new twist: The patients are divided into those with addresses and those without, she notes, in order to direct the latter to a clinic that now specifically addresses the needs of the homeless population.

Pundt says she can distinguish between the two groups because registrars know to enter the hospital's address for those who don't list a residence. At that point, she faxes the appropriate face sheets either to St. Elizabeth's or to El Rio, the clinic handling the homeless population.

"Our social worker tends to get involved with the homeless anyway," Pundt notes. "There are several brochures we have about services. Before this program, all these people were slipping through the cracks."

All of the individuals referred to the two clinics have been discharged from the ED, she points out. "Some of them may not need follow-up care, but we still want to refer them so that if they need a flu shot or get sick again and have a minor problem, they will call St. Elizabeth's or El Rio."

In addition to the daily screening of face sheets, Pundt adds, ED staff can alert her or the social worker if they think a patient has a particular need or can benefit from referral to one of the two clinics.

If that happens, she says, "I make sure they get sent over and I also make a follow-up phone call. Anything brought to my attention today, I will deal with."

While it's difficult for nurses — who are focused on clinical issues — to consistently screen for likely candidates, Pundt notes, educating staff to pass on information about specific cases to her or the social worker is one of the goals of the program.

In one instance, Pundt recalls, a young man with a dislocated shoulder made several visits to the ED and was ultimately referred to St.

Elizabeth's for orthopedic care. A self-employed construction worker, the man originally didn't meet the criteria.

"He couldn't work and he couldn't make money, but then [he qualified] when he got down to having no money," she says. "The only way he could get back to work was to get his shoulder fixed. Everything was going well the last time I talked to him."

Another case recently brought to her attention involved a woman who came in to be treated for one condition, but during triage also was found to have extremely high blood pressure. "When she was asked what she took for that, she said, 'Nothing — it's too expensive.' The [triage nurse] alerted me, I got her connected with St. Elizabeth's, and she is now on medication."

Another goal of the referral effort, Pundt notes, is to identify children who might qualify for Kids Care, an arm of the AHCCCS program.

"Say an adult comes in, but in a follow-up phone call to the person, we find out he has a family," Pundt says. "We may find that the parents make too much money to get total AHCCCS [coverage] for themselves, but the kids are eligible."

Local school systems also help identify children who are eligible for the program, she adds.

During the 14-month period between August 2006 and October 2007, there were 1,325 referrals for patients "who aren't emergencies, don't have insurance, and don't have regular medical care" from St. Mary's Hospital to St. Elizabeth's Health Center, according to **Nancy Johnson**, RN, PhD(c), executive director of the health center.

Center uses sliding fee scale

St. Elizabeth's serves individuals who are not eligible for federal- or state-funded health care programs, Johnson notes. They are put on a sliding scale and pay whatever they can afford, she says.

The effort, which began as a pilot program, will be continued, she says, noting that of the patients referred to the health center, 327 — including some family members — were successfully registered, and about 132 "have established care" at St. Elizabeth's.

"The definition of that is that they have actually shown up, registered, and had one appointment with a primary care provider," Johnson adds.

"Where the rubber meets the road is if they continue [to come to the health center] and we see that we don't have other hospitalizations,"

CNE *questions*

1. According to Peter Moran, RN, C, BSN, MS, CCM, if you feel a patient is ready to go home and the physician disagrees, what is the first thing you should do?
A. Ask if there is something you can do to address the physician's concerns.
B. Tell him or her that the patient has to go home anyway.
C. Report the physician to the administration.
D. Call on your physician advisor for help.

2. At Good Samaritan Hospital, case managers write thank-you notes to physicians, nurses, therapists, and leaders who have been helpful in documentation or throughput issues.
A. True
B. False

3. Which of these are suggestions for a strong case manager-physician collaboration?
A. Shared successes.
B. Talk face to face.
C. Don't talk about money.
D. All of the above

4. A clinical documentation program at Jupiter Medical Center increased reimbursement by how much in the first year?
A. $278,000
B. $325,000
C. $142,000
D. $248,000

Answer key: 1. A; 2. A; 3. D; 4. A.

CNE 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. ■

she notes. "That is yet to be seen."

Further breaking down the number of referrals, says Pundt, 91 people have had more than one appointment at St. Elizabeth's, and 159 individuals received help through the center's prescription assistance program.

"The numbers keep whittling down, but they are for a program that is not much more than a year old," she adds. "We are still learning how to promote it to the community."

Of the 1,325 referrals to St. Elizabeth's, Pundt says, staff were unable to reach 178 people because they had given their names or other information incorrectly.

Various locations help initiative

Between April 2007 when St. Mary's began its program with El Rio and July 2007, about 160 homeless individuals were referred to that clinic, Pundt notes. "They only made contact with 16 people who followed up. There were a lot they just couldn't track down."

In addition to continuing its partnership with St. Mary's, Johnson says, St. Elizabeth's staff will be seeking out those in need of affordable care in other places. One of those locations, she notes, is a small volunteer clinic in south Tucson called Clinica Amistad.

"There is no outpatient care of any kind in that area, so it's not easy [to get treatment] if you wake up in the morning and aren't feeling well," she says.

Clinica Armistad is run by volunteers, Johnson adds, and is open only on Monday evenings. "Seventeen to 30 people show up who have no physician, no money, no insurance.

"We started sending one of the community health workers from our center there to let people know we're here," she says, "and to do health education with whoever shows up." The plan was to encourage them to enroll at the center, Johnson adds, "and start getting them involved in preventive health care as well as acute care — things like flu shots and PAP smears."

The message her staff want to get across, she says, "is that we can offer services based on what they can pay." As a result, it is anticipated that the hospital ED will see fewer uninsured people who are not emergencies, and there will be fewer hospital admissions.

Key to the success of St. Elizabeth's programs, Johnson notes, is the support of Tucson physicians. "Our great blessing is that we have over 150 volunteer physicians who help us." Physicians donated care worth $750,000 during the past fiscal year, she adds, including expertise, X-rays, and use of the vascular lab, among other services.

One of the challenges center staff face in their efforts to provide care to the uninsured, she says, is the reluctance of many individuals to seek treatment — no matter how crucial — that they know they can't afford.

"We have one woman in for breast cancer treatment who had a palpable lump," Johnson notes. "She said, 'I don't want to leave my family with a large medical bill. I'd rather leave my savings account to them.'"

St. Elizabeth's staff were able to tell the woman about funding that is available from grants and from the Komen Foundation, she says, as well as care from volunteer clinicians.

Models 'integrate family, neighborhood'

"The projects we work with are models that integrate family and neighborhood," Johnson explains. "If I'm hanging out with people who eat healthy and take a walk every morning, I'm not as likely to eat doughnuts and lie in front of the television. A lot of people are influenced by those around them."

The Monday night sessions that St. Elizabeth's community health workers conduct at Clinica Amistad, for example, include nutrition education and chair exercise sessions "with whoever happens to be there," she says. "It's very impromptu. They might say, 'We will talk tonight about protein and where to find it, or calcium and what foods it's in.'"

Staff might start a conversation with patients about the foods they like to prepare and suggest ways to make them healthier, or discuss stress management activities, Johnson says.

"Our education is twofold," she adds. "One [approach] is to provide health information, but another is to build trust and to convince people that [St. Elizabeth's] will be a comfortable place to get care."

Cooperation between health center and hospital employees is a continuing focus, Johnson notes. "When one of our patients needs to have surgery for cancer, we call ahead to let the hospital know the person doesn't have insurance, so they can be prepared to help rather than have it be a traumatic experience."

St. Elizabeth's personnel work with hospitals to set up packages and payment plans for uninsured

patients, she says, including an arrangement with Tucson's University Hospital on obstetrics care.

The health center has obtained funding to establish an electronic medical record system (EMR), Johnson says, which is expected to be in place by this summer.

"That will help us tremendously," she adds. "We're building in some templates for all the education and health prevention [programs] we're doing."

In the case of patients who are referred from the ED, Johnson says, "we will be able to measure the power of these interventions. We might have a diabetic who has improved — his hemoglobin A_{1C} has gone down, which is the gold standard we use for control of diabetes."

Using the EMR, she explains, the individual would be logged in as an ED referral, with notations in the record showing that he came to the nutrition class and did the chair exercises, and that those things actually affect clinical outcomes.

"Most EMRs are designed for what happens in the exam room, and that is certainly helpful; but the premise we have is that [the traditional] model of care needs adjustment and that some of the preventive interventions may affect everything else."

Physicians will be able to pull a person's record, she adds, and say, "'Oh, I see you've been going to this exercise class.'

"We live in a really abundant society," Johnson point out, where a lot of money is channeled toward health care. "Money is spent on treatment and hospital care. It is a disease-based model. We reimburse hospitals and specialists for surgery, radiation, and chemotherapy, but we don't have a lot of funding on the front side for prevention."

If an uninsured person feels fine, she may not see spending $75 for a mammogram. "I believe there needs to be a shift to get money on the front side and help people who are working but who can't afford to pay $1,000 a month for insurance."

*(Editor's note: **Cassandra Pundt** can be reached at cpundt@carondelet.org. **Nancy Johnson** can be reached at njohnson@ccs-soaz.org.)* ■

ED patient advocate draws on nursing skills

'It's nice to get involved, address the issues'

Working for 10 years as emergency department nursing manager at St. Mary's Hospital in Tucson, AZ, **Cassandra Pundt**, RN, CEN, recalls she was constantly struck by the "tremendous need" for a patient advocate specifically dedicated to the ED.

"Because of the hotbed [of ED activity] that we are, there are real bottlenecks," she says. "There is so much anger and distress when patients have to wait. Sometimes when the admit beds are full, there can be up to a two-day wait for a bed. There can be ICU patients in the ED [waiting for admission]."

The demand for ED services is worse in different parts of the country, she notes, "and in Arizona, in particular, there is a pretty big problem."

As ED nursing manager, she received referrals from the hospital's patient advocate, Pundt says, "but sometimes other things get a higher priority than patient complaints," and she and the two assistant managers were unable to follow up as thoroughly as they would have liked.

Concerned about the need for patient advocacy in the ED and ready to "let go of the manager hat,"

CNE objectives

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

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

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she adds, Pundt wrote a job description and talked to her superiors at the hospital, who accepted her proposal. She began her job as emergency services patient representative in August 2006.

"I wanted to ratchet down from management because I was planning to retire in a couple of years," Pundt notes. Additionally, she says, "as much as I hate to hear complaints, it's nice to get involved indirectly and address the issues."

As part of her job, Pundt teaches customer service classes to staff, focusing on "how to deal with difficult patients, difficult situations — all the things you want people to demonstrate as professionals."

"We also created a bereavement support group, and follow up with patients who have lost a loved one," Pundt says. "We deal with them at the time, offering support and giving them a nice packet of information about the grieving process, and then send a sympathy card from the department."

A few weeks later, she notes, Pundt makes a phone call to the family members who have experienced a loss.

"We've had a very positive reaction," she adds. "People are very appreciative. I got a thank-you card from a family thanking me for sending them a card."

Pundt, who also has worked as a cardiac nurse, believes her nursing background adds an important dimension to the advocacy role.

"Many places have advocates, but they're not nurses," she says. "That's fine; but with the critical thinking skills of a nurse, you can work through a lot more troubleshooting — especially if there is a quality-of-care issue. I do chart reviews and pick up on things I might refer to other departments, such as risk management." ■