HOSPITAL CASE MANAGEMENT™

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

AHC Media LLC

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Creativity is the key to managing the care of patients without insurance

Linking patients with primary care keeps them out of the hospital

As health insurance costs escalate and employers reduce coverage for employees, raise deductibles, or stop providing health insurance altogether, hospitals are providing care for an increasing number of patients who have no means to pay.

The federal government estimates that 47 million people had no health insurance of any kind during 2006, and all indications are that the number will continue to increase, says **Donna Zazworsky**, RN, MS, CCM, FAAN, director, network diabetes and outreach for Carondelet Health Network in Tucson, AZ.

The uninsured come from all walks of life, all age groups, and all educational levels, she adds. "The largest number of uninsured have less than a high school degree but there are still a large number of people with professional and graduate degrees who are uninsured," she says.

Having a full-time job doesn't guarantee access to health insurance, Zazworsky points out. In 2006, 18% of the total work force was uninsured, accounting for 28 million of the 47 million uninsured.

People whose incomes fall below the federal poverty level are the only ones eligible for federal programs; that leaves a lot of people who don't qualify for the program but can't afford the cost of premiums even if they work for a company that offers health insurance benefits.

Patients stuck in ED, acute care

Patients who don't have insurance often remain in the acute care hospital longer than necessary because they have no funding for home health or durable medical equipment. Others have extended lengths of stay in an acute care facility because facilities that can provide a lower level of care won't take patients when they won't be reimbursed for the care.

Uninsured patients, many with chronic illnesses, are flooding the nation's EDs because they can't afford treatment at a primary care provider or they have no money to fill their prescriptions.

"The uninsured aren't being connected to primary care and don't have the money for medications. Patients come into the emergency department and are stabilized but then sent home with no resources to help them manage their condition. The problem is exacerbated because people without insurance are not having regular check-ups and preventive care," Zazworsky says.

Hospital case managers are in a position to help in all of these situations, she adds, but it's a challenge they can't meet alone.

"Case managers need to know what resources are available in their area and work with community agencies and other providers to help the uninsured find a medical home so they can stay healthy and out of the hospital," Zazworsky says.

Network for solutions

In communities across the nation, hospitals are collaborating with local agencies and other providers to provide medical care for patients without funding and to create a bridge between acute care and primary care.

For instance, Harborview Medical Center in Seattle has dedicated a case manager to patients with chronic illnesses who are treated in the hospital's emergency department. "In essence, I'm a financial counselor, disease management nurse, and social work coordinator," says **Audrey Paisley**, RN, diabetes and asthma case manager.

If patients are uninsured, the Harborview staff try to connect them to services that can get them covered by Medicaid or the state of Washington's basic health plan, adds **Daniel Lessler**, MD, MPH, associate medical director.

"We work to address other psychosocial needs as well. Some of the patients are homeless and we connect them to sources that may help them find better housing," he says.

The model helps build bridges between the patients and resources in the community that can help them better manage their chronic diseases, Lessler adds. **(For details on how Harborview's program works, see related article, p. 68.)**

"Health care and community-based organizations need to create new ways of collaborating to help people stay healthy," he says.

Help patients reconnect with primary care

Helping patients connect with a primary care provider should be a priority for hospital-based case managers whether they are in the emergency department or the acute care unit, Zazworsky says.

Hospital case managers should become familiar with what resources for the uninsured are offered in their community and help their patients access them. **(See article, p. 67.)**

"There are a lot of health care delivery systems

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in the community that can provide care for the uninsured," Zazworsky says.

Help patients find a medical home either though a federally qualified community health center, a clinic that provides free or reduced care, or a faith-based health center. Make the first appointment for your patients before they leave the hospital, she suggests.

In order to understand why patients keep returning to the hospital or the ED , case managers need to be aware of what is going on in a patient's life when he leaves the hospital, Zazworsky says. For instance, a patient may be repeatedly hospitalized for diabetes because he didn't get his medication or doesn't check his blood sugar level.

"Patients often wind up in the hospital if they can't afford their medication or if they cut their pills in half to make them last longer," she explains.

Asking patients how they perceive their health is a good way to determine who is likely to be readmitted, Zazworsky notes.

"Patients who perceive their health as being good to excellent are less likely to be rehospitalized, even if they are very sick," she says.

Identify your patients' potential health care and medication needs, benefits that are available to them, barriers to receiving care, and appropriate resources, Zazworsky suggests.

Look beyond the immediate situation to include what is going on in a patient's life when he or she leaves the hospital, she advises. Find out what kind of support system the patient has at home, financial issues, transportation problems, or other roadblocks to compliance.

Case managers should work with social workers in the hospital and social service agencies in the community to make sure their patients have shelter, food, and other basics.

Help your patients get on food stamp programs, energy savings programs, and other types of assistance.

"If someone is not living in a safe and secure environment, if they don't have food or are worrying about whether their utilities are going to be cut off, they aren't going to take care of their health. Many times people have to make the choice between paying an electric bill and getting a scan done," she says.

Determine an uninsured patient's eligibility for federal and state programs and initiate the paperwork, Zazworsky advises.

Make sure that someone is available to follow up with the patient on paperwork and their eligibility.

Case managers may want to talk to their manager or directors about setting up a program to identify uninsured patients so they can be screened for eligibility for various programs and so someone can set up the process to get them into primary care, Zazworsky suggests.

Health care resources for the uninsured and indigent

- **Federally qualified community health centers:** These centers are funded through federal grants to provide primary and preventive health care in medically underserved areas and must provide the uninsured if they meet guidelines. For more information, see the Bureau of Primary Health web site, **http://bphc.hrsa.gov/**, or the National Association of Community Health Centers web site, **www.nachc.com**.
- **Faith-based community programs:** Religious organizations in many communities have operated health centers, clinics, and parish nursing programs for the indigent for many years. Others have been established through the federal government's faith-based and community initiatives. For more information, visit **www.hhs.gov/fbci**.
- **Rural health clinics:** These clinics provide primary care in underserved rural areas and are certified to receive special Medicare and Medicaid reimbursement. See the National Association of Rural Health Clinics web site at **www.narhc.org**.
- **University nursing centers:** If there is a college of nursing with a nurse practitioner program in your community, it may have a clinic that provides health care at a reduced cost.
- **School-based clinics:** Some communities have clinics in the local schools, staffed by nurse practitioners who give the children immunizations and health checks, and in some cases, also may see family members.
- **Pharmaceutical assistance programs: Needymeds.com** offers information and application forms for medication assistance programs from pharmaceutical companies. To receive free medication, patients have to be connected to a primary care home, which receives and distributes the medication.
- **Local and state programs: CoverThe Uninsured.org** includes information and statistics about the problem as well as specific information about resources available in each state.
- **Other sources for health care for the uninsured or indigent** include state departments of health services, United Way agencies, community agencies, and national foundations. ■

Help your patients apply for pharmaceutical assistance programs, help them obtain a supply of medication to bridge the gap until the program kicks in, and make sure that someone follows up, she says.

Patients who receive pharmacy assistance must have a medical home because the programs require that a nurse or physician distribute the medication, Zazworsky adds.

Regional health information exchanges are being created across the country so providers can share information and provide more cost-effective care. For instance, participants in the Southern Arizona Health Information Exchange include all hospitals, health plans, and providers in the area. They are working together to create an information system so that if an uninsured patient shows up at one hospital, the staff can check to see if a test or lab work has been done recently by another provider.

"This will enable them to use any current information without repeating tests or procedures and to see what the treatment is so they don't have to start over with a patient," Zazworsky says.

"Everybody has the same problem of escalating costs and how to reduce them. This will follow patients from location to location," she says.

*(Editor's note: For more information, contact **Donna Zazworsky**, director, network diabetes and outreach, Carondelet Health Network, Tucson, AZ; e-mail: Donnazaz@aol.com.)* ■

Keeping chronically ill patients out of the ED

Case manager links patients to primary care

When chronically ill patients who have no insurance coverage and no medical home come into the emergency department at Harborview Medical Center in Seattle, they are referred for follow-up to a nurse case manager who links the patients to a primary care provider and helps them learn to manage their disease.

In a small sample of patients studied at the beginning of the program, nearly half of the patients referred to case management were connected with a primary care physician and subsequently had low emergency department utilization, according to **Daniel Lessler**, MD, MHA, associate medical director at Harborview Medical Center and associate professor of medicine at the University of Washington.

"Patients who become established with a primary care provider don't use the emergency department as much and have better outcomes. We are greatly encouraged by the outcomes and we believe that we are really making a difference to these patients," he says.

The program is being funded through Steps to Health King County, part of a nationwide initiative from the Centers for Disease Control and Prevention (CDC) to halt and manage chronic disease.

The initiative was one of several cited when Harborview received the prestigious Foster G. McGaw Prize for Excellence in Community Service. Each year, the $100,000 prize is presented to a health care organization that provides innovative programs that significantly improve the health and well-being of the community.

Other programs for which Harborview was recognized include satellite clinics in downtown Seattle for the homeless and uninsured; supported housing and unemployment programs for the mentally ill; community house calls by bilingual and bicultural caseworkers to the immigrant population; and the Injury Free Coalition for Kids of Seattle, a partnership to promote the safety of children in inner-city and immigrant communities.

Like other safety net hospitals, Harborview Medical Center has an overcrowded ED and faces an epidemic of diabetes and high utilization rates by people who use the ED for primary care.

"An emergency department visit is a sentinel event that should not happen with asthma and diabetes. We knew that we needed to be making more of an effort to connect the underserved and vulnerable population to primary care," Lessler says.

The ED refers patients who have a diagnosis of diabetes or asthma and who do not have a primary care provider to **Audrey Paisley**, RN, diabetes and asthma nurse case manager. She follows a disease management algorithm and is backed by Lessler and a nurse practitioner who help when questions arise.

Once patients are identified as eligible for the program, Paisley attempts to find them through telephone calls, letters, and assistance from homeless shelter staff and nurses. She typically carries a caseload of 90-100 patients.

"Many of these patients speak English as a second language. Some have cell phones. Some have no telephone. Some are literally living under bridges. Others are in shelters. I have the most

success with patients who have cell phones and who want to be engaged in managing their health," Paisley reports.

Upon initial contact, she conducts a questionnaire; addresses any urgent financial, medical, and psychosocial needs; and identifies barriers to self-care. Then she develops a care coordination plan, makes a primary care appointment at a clinic, and mails educational materials to the patient and/or schedules the patient for classes.

Paisley works with the patients to establish a relationship with a primary care provider in the area in which they live, whether it is a community clinic that provides free or discounted services or one of Harborview's clinics. For instance, some of the patients who are newly arrived immigrants may receive primary care in the hospital's international medicine clinic.

"Many of the patients come as far as 30 miles for treatment. The ultimate goal is to find a community clinic close to where the patient lives or get them an appointment at one of Harborview's clinics," Lessler says.

The goal of the program is to ensure that patients are established with a primary care physician, to get them connected to a program that offers free or reduced care, and to keep patients with chronic diseases out of the emergency department when their needs can be met by a primary care provider, Paisley says.

Paisley helps eligible patients get signed up for community resources such as Medicaid, the hospital's charity care, the Department of Social and Health Services' programs, and the hospital's low-income allowances program in which low-income patients pay only a portion of the bill.

She sets an appointment with a primary care provider and follows up with a letter with a reminder of their appointment, a lab referral form, and directions to the lab and clinic.

"When I initially talk to them, most patients have just been diagnosed and it's very difficult to engage them in any form of education. The majority of questions these patients have are about financial issues and transportation to the hospital," Paisley says.

The initial call

During the initial call, Paisley helps the patient get set up with a financial counselor, determines other consultations that may be needed, and makes sure the patient is taking his or her medicine as prescribed.

"In the early stages, one of my main goals is to assure that the patient's medical care is covered so they won't worry about getting a bill. If they get a lot of bills, they tend to stop coming and end up back in the emergency department," she says.

Paisley then sets up a meeting with a nutritionist for newly diagnosed diabetics and provides information on classes on diabetes or asthma offered in the hospital's Patient and Family Resource Center.

After the first few conversations, she begins to address self-management issues, such as blood glucose monitoring for diabetics and peak flow monitors for people with asthma.

"I contact them every two weeks. Once they are settled into the routine and doing self-monitoring, I work with them to set goals and determine strategies to help them meet the goals," Paisley says.

During the follow-up calls, Paisley educates the patients about following nutritional guidelines in their diets, getting regular exercise, and following other aspects of their care management plan, such as not smoking.

During each conversation, she stresses the importance of medication compliance. For instance, with asthmatics, she explains the benefits of using the controller medicine regularly instead of relying on their rescue medicine.

Before she calls the patients, Paisley accesses their medical records and reviews the laboratory values and other results from the last primary care appointment. She determines when their last medication prescription has been filled, and if it hasn't been filled for a while, discusses it with the patient, and finds out what barriers need to be overcome.

Paisley also checks the status of the patient's funding application and whether the paperwork needs to be updated or reviewed.

If patients fail to show up for an appointment or call to cancel an appointment, Paisley follows up to find out what barriers are interfering with compliance. If transportation is an issue, she can refer them to programs that provide reduced bus or free cab fare for eligible patients.

Paisley follows up with the patients on a regular basis for about six months on average.

"Some are fairly educated and able to keep track of their appointments and their medication regimen, and I can close those cases within two to three months. I follow some for a year, primarily because they don't understand the system; they don't know how to arrange transportation or order medication refills," she says.

Paisley gives patients a reminder call the day before they have an appointment. Before she releases them from the program, she stops calling to see if they will still remember the appointment.

"If they don't show up for the appointment without a reminder, it tells me they need a little more case management. It's a little test to see if they're ready to go out on their own," she says.

If her patients have another emergency department visit, Paisley is notified and immediately follows up.

One of Paisley's biggest challenges is to educate patients about how the health care system works.

"Many of the patients have low literacy. They don't speak English well and are afraid to share personal information about themselves, which they have to do when they apply for pharmacy benefits. They simply do not understand the health care system," she says.

Some patients don't understand that they need to show up for their primary care appointments on time or that they can't just walk in to a clinic and demand to be seen. Some need help with tasks as simple as calling the pharmacy refill line to reorder medications.

"I ask my patients to call me if they think they need to go to the emergency department. I might be able to get them a walk-in appointment with their clinic or help them get their medication refilled if they don't understand how. I work with them to keep them out of the emergency department," she says.

Very few patients in the program who make regular visits to a primary care physician go back to the emergency department, Paisley reports.

"A few asthma patients have gone back but it's because of language differences and their lack of understanding of how the medication works," she says.

*(Editor's note: For more information, contact **Audrey Paisley**, RN, diabetes and asthma nurse case manager, Harborview Medical Center, e-mail: paisleya@u.washington.edu.)* ■

Expedited discharge fund helps uninsured patients

Plan frees up beds for patients who can pay

When patients are medically ready to leave the acute care hospital and have no coverage for post-acute care, it's a "no-brainer" for the hospital to pay to move the patient to a lower level of care, says **Jay Cayner**, director of social patient and family services at the University of Iowa Hospitals and Clinics.

"At minimum, providing care in an alternate setting won't cost more than taking care of the patient in our hospital. In addition, this gives us an opportunity to fill the bed with someone who needs tertiary care and who does not have a payer. With a hospital census that hovers around 80% occupancy, it makes all the sense in the world," Cayner adds.

Located in Iowa City, University of Iowa Hospital is a tertiary care teaching hospital with about 700 beds. It's a regional hospital that provides specialty care for highly complex patients from all over Iowa and surrounding states.

The hospital has created an expedited discharge fund to pay for medical equipment, courses of IV antibiotics, special transportation, and other goods and services that are holding up a patient's discharge. The fund may be used for pharmaceuticals, including providing medications for patients with Medicare drug coverage "donut holes," physical therapy, occupational therapy, intravenous therapies, wound vacs, and other equipment.

If a patient's Medicaid coverage is pending, the hospital may work out an arrangement with a post-acute facility to take the patient and will guarantee payment at 95% of the Medicaid rate for 90 days, until Medicaid kicks in.

Patients must meet strict requirements to qualify for the expedited discharge funds. They must be medically ready to go, have medical needs for which they would otherwise have to stay in the hospital, and have no payer, Cayner says.

The fund helps the hospital's social workers and case managers find a safe discharge for a patient who otherwise would have to stay in the hospital, says **Jill Carroll**, MSW, LISW, a social worker at the hospital.

"Many highly complex patients are transferred to us because local hospitals are not able to provide specialty care. Creating a safe discharge for these patients who have no insurance and who need a lot of post-acute service is a huge challenge," Carroll adds.

The hospital employs a full-time bachelor's-level social worker who helps patients with

(Continued on page 75)

CRITICAL PATH NETWORK™

Tom's story: Challenges that ED frequent fliers present

Hospital CMs collaborate with community agencies

A middle-aged male patient — let's call him "Tom" — showed up in the emergency department at Massachusetts General Hospital in Boston about a year ago complaining of pains in his chest and legs.

Tom subsequently made more than 50 ED visits to Massachusetts General alone in 10 months and has been in the emergency department of at least five other Boston hospitals multiple times. He's been a patient numerous times in acute care hospitals, nursing homes, and inpatient psychiatric units all over the state.

"He never stays long. He just walks away. Whether he's admitted to the medical side or to the psychiatric side, he has the right to make the decision to leave, and he does. The cost to the system is huge because he keeps coming back to the emergency department where the staff must, by law, provide evaluation and treatment," says **Peter Moran**, RN, C, BSN, MS, CCM, emergency department case manager who is working with the Massachusetts General treatment team, Healthcare for the Homeless, and community and state agencies to help keep Tom out of the ED and connect him with the appropriate community resources.

Tom's medical problems include a history of large clots in the lower extremities and pulmonary embolism, along with a schizophrenic affective disorder, Moran reports.

"His medical issues are concerning but he will tell people that he is fine. He can recite every medication he's supposed to be on and an address where he lives, but a lot of it is not true. He knows the system from one end to another and knows how to manipulate the system to get attention," Moran says.

Patients such as Tom present a challenge to case managers because they can never know what is really going on with them, Moran says.

The first few times Tom came into the Massachusetts General ED, the staff had no reason not to believe him when he said he had an apartment but no telephone, Moran says.

Over time, based on his usage of the health care system, Moran began to feel strongly that Tom was homeless.

The staff knew that he had been treated at other EDs because he'd come in with cardiac stickers on his chest from other hospitals all over eastern Massachusetts. In addition, some residents who worked at other emergency departments in Boston as part of their training recognized him from other facilities. A traveling nurse at the hospital knew Tom from working at an ED at a hospital in New York.

Breaking the cycle

"This patient has been using the hospital and emergency department as a home and a support system. I have been working with a multidisciplinary team to develop a plan of care that breaks the cycle," he says.

Most recently, a hospital in northern Massachusetts placed Tom in a nursing home. He walked out after a short stay and is believed to be back in the Boston area.

Tom is disabled and receives disability benefits but since he doesn't have a permanent address and the nursing home he left became the payee, Moran is concerned that he may not be getting his money.

Tom is probably panhandling and relying on soup kitchens for meals, Moran says.

But after months of collaboration between hospitals, community, and government agencies, when Tom shows up again in the ED, there's a plan in place to get Tom the kind of care he needs in a setting that is more cost-effective than the emergency department.

"These kinds of cases are extremely costly. We have been working to come up with a plan to keep him out of the emergency department and get him the care he needs in a more cost-effective setting. There is a whole population of patients who are in this situation and they create a huge cost to the system. It's a fairly small population, but these are heavy utilizers of the health care system and they often fall between the cracks," he says.

When patients such as Tom show up in the ED, staff who have dealt with them over and over are tempted to say, "'It's Tom. He's here again. There's nothing wrong with him,'" Moran says.

"The more I saw Tom, the more I thought he wasn't really having medical problems but I couldn't run the risk of blowing him off when one of his complaints may be real. It's a Catch-22 situation that happens with other patients who make repeat visits to the emergency department," he says.

Tom is a friendly, likeable guy who was depending on the hospital personnel for his social interactions, Moran says. "He'd come to the front desk and the staff would give him money to buy himself coffee and a donut. We realized that we were reinforcing his behavior," he adds.

The Massachusetts General team that has worked with Tom includes social workers, case managers, and a psychiatric clinical nurse specialist who works in the emergency department,

"Enough of us started saying we needed to do something about Tom and were able to bring resources to bear. We tried to develop a care plan to hook him up with primary care in the community," Moran says.

Moran worked with other staff at Massachusetts General to find community case management through the Department of Mental Health or the Medicaid case management program.

"We tried to get a case worker with the Mental Health Homeless Outreach Team to take his case but since Tom said he wasn't homeless, they initially weren't interested in working with him," he says.

The Massachusetts General team was able to make the case that Tom was homeless by collaborating with staff at other hospitals and showing that Tom had been in one ED or another every night for three weeks.

Then, the issue was getting Tom to a place where a homeless outreach worker could conduct an interview. When Tom came to the ED with lower extremity pain, the outreach worker conducted an assessment and concluded that because of medication adherence problems, he could be admitted to a skilled nursing facility or a long-term care facility.

Tom was evaluated by a psychiatrist who determined that he had sufficient insight to make his own decisions, which was not to go to another facility after discharge from the hospital.

"We knew other hospitals had sent him for psychiatric evaluations but they'd always release him. The issue became how to develop a strategy that recognizes his right to make his own decision but that helps him change his decision and manage his own health care," he says.

An involuntary commitment was out of the question because he was capable of making his own decision. The team explored whether they could have a guardian appointed but determined that he was not technically a candidate for a guardianship.

Now that Tom has a case manager in the Department of Mental Health Services, the EDs know who to call when he comes back in.

The plan called for a hospital to discharge Tom to a specific shelter where the homeless outreach worker could check on him on a daily basis, and where Tom could create bonds and develop a relationship.

"If Tom comes in now, he'll be evaluated medically and if he is cleared, we'll try to get him to go to the Pine Street Shelter medical clinic and see the homeless outreach worker stationed there. We are hopeful that the outreach person can create bonds and develop a relationship with him," Moran says.

Tom's story points to the challenges that case managers face in dealing with issues of recidivism in the EDs, particularly with patients who have complex medical and psychosocial needs, Moran says.

The problem is exacerbated when patients are deemed to have the insight and capacity to make their own decisions but are struggling to survive, he adds.

"We do very well if someone falls into one silo, but we have real challenges with cases like this. Emergency department case managers should understand not only the medical and behavioral piece, but the community resource piece, and the

financial piece in order to develop a plan of care for patients who are frequent fliers. In addition, we need the skills to mobilize people from many agencies and the time to coordinate resources for them," Moran says.

One issue that impedes dealing with patients such as Tom is getting the information to flow between hospitals and community agencies, Moran points out.

"The challenges are out there. We don't have an integrated medical record that flows with patients, so we're constantly trying to find out what the reality is," he says.

Coordination between facilities and community agencies to develop strategies to address the needs of patients is a very labor-intensive process, Moran points out.

"It's amazing how taxing one case can be. We are fortunate in Boston to have resources but we still don't have a solution for Tom even though a lot of people all over the city are working on it," he says.

*(Editor's note: For more information, contact **Peter Moran**, case manager, Massachusetts General Hospital, Boston, e-mail: pm250119@comcast.net.)* ■

Technology increases patient throughput

System provides information in real-time

Oakwood Hospital and Medical Center reduced the number of patients waiting more than four hours in the emergency department by 35% and cut salaries by $60,000 after installing an electronic bed management system that provides information on bed availability and patient status and location in real-time.

"We had been using a manual system for bed management and knew we were not using resources efficiently. Patient throughput was a real issue. We were looking for real-time information to improve the patient experience and patient safety," says **Monica Donofrio**, RN, BS, CPHQ, senior director for care management and access.

The salary savings were generated by eliminating staff whose main responsibility was to round on the floor to find empty beds and communicate with the bed control center. In addition, because the system is paperless, the bed control center was able to decrease the paper it prints each day by 250 sheets, she adds.

The hospital's electronic "whiteboard" interfaces with other systems in the hospital, giving staff all over the hospital information in real-time.

"This system enables us to admit patients more efficiently and to move them along the continuum in an efficient and effective manner," Donofrio says.

The hospital uses an off-the-shelf capacity and throughput management software package with some customization.

Large electronic displays throughout the hospital have color-coded and time-stamped icons that allow the staff to see the status of every room and what is going on with the patient at a glance without having to log in to any system.

For instance, rooms for patients in observation status are shown in blue; those with patients with a scheduled discharge are green striped; empty rooms are white; rooms being cleaned are brown striped.

Icons on each room provide additional information, such as identifying patients with a core measure diagnosis or those who need consultations for case management or social work. Other icons indicate if a patient needs transportation, when diagnostic results are available, when medications are ready, and if there is a patient safety alert, such as a potential for a fall.

Timers for all assigned patients and beds alert staff to the time the discharge orders were issued, when patients were placed in observation status, when patients will be leaving the hospital by ambulance, and other information.

When the result of an X-ray, MRI, blood test, or other test or procedure is posted in the hospital's electronic information system, an icon pops up on the patient's room and stays for 30 minutes, notifying staff that the results are in the system. If the results are normal, the icon is blue. If they are abnormal, the icon is red. If they are a critical value, the icon is striped.

"If case managers or bedside nurses are waiting for results before developing a plan of care or discharge plan, they can see when they're available, rather than having to go in and out of the system to check," she says.

The system helps cue case managers to work on the case so that patient doesn't exceed his or her expected length of stay.

For instance, if a patient is in observation status, the screen shows that room in blue with a timer that indicates how long the patient has been in that status.

"When the case manager arrives in the morning and sees someone who has been in observation since the evening before, he or she knows to expedite the plan of care and ensure that the patient is either admitted or is ready for discharge," Donofrio says.

After the patients are admitted, staff can use a mouse to hover over the room and determine the patient's insurance coverage, length of stay, and other information.

"This allows the case managers to see which patients need utilization review so they can begin to process that work," Donofrio says.

All patients who are admitted to the hospital, flow through the bed control center. About 55% of patients are admitted through the ED.

When patients are waiting for a bed, the bed placement staff are able to look at the electronic whiteboard and go through the hospital unit-by-unit or in special screen views to see all potential discharges, all pending discharges, and all empty rooms.

When an inpatient is assigned a bed on a different unit, it feeds into the system.

"With an in-house transfer, we can see how long we're waiting for a patient to move from one room to another. The system is a tool that helps the nursing leaders manage an efficient throughput on their units," she says.

Discharge within three hours of order

The system helps the hospital meet its goal of discharging a patient within three hours of the physician signing a discharge order.

Each day, case managers and unit nursing leaders manually input into the system any patients with an 85% or greater chance of discharge.

"Based on the patient's DRG or clinical condition and knowing the physician's discharge plan, the case manager uses the electronic system to notify everyone on the floor that the patient is likely to leave," Donofrio says.

When the unit case management placement coordinators process an ambulance transfer, a time pops us, alerting the entire unit-based interdisciplinary team to make the final discharge arrangements.

"This enables everybody on the patient care team to organize their work around the timing so the patient is well prepared to leave when the ambulance arrives," Donofrio adds.

The housekeeping system interfaces with the main system, which notifies the housekeeping department when a patient is discharged. The system includes information on specific types of cleaning needed, such as if the room is an isolation unit.

The housekeepers enter codes through the telephone when they start to clean the room and when they have completed the cleaning process. All phases of the bed cleaning process are displayed on the electronic whiteboards and allow bed control to assign patients before the cleaning process is completed.

"Patients are much happier knowing which bed they will be admitted to and knowing it will be only a short while until the room is ready," Donofrio says.

There are electronic whiteboards at each nursing station, on each hallway, and in the physician lounge, allowing the doctors to see at a glance where bottlenecks are occurring so they can move their patients out faster if appropriate.

Some contain information just for the floor on which they are installed. Others, such as those in the bed control department, nursing office, or physician lounge, have an enterprise view that includes all nursing units and all waiting areas.

Radio-frequency devices implanted in the patient chart help the staff track when patients are in and out of the room. The electronic boards show where every patient is at any point during the day.

For instance, if a physician comes to the hospital to see a patient, he or she can go into the physician lounge and see that the patient is in the X-ray department.

"When physicians identify that a patient is not in their room, they can go to that treatment or diagnostic area to evaluate the patient and make their notes on their assessment findings in the chart. It makes their time very efficient," she says.

The hospital has a geographic-based care management model. Most of the patient care units are DRG-based.

On the inpatient side, one case manager and one social worker are assigned to a 32-bed unit.

The case managers handle utilization review, home care referrals, and resources used within the organization. The social workers focus on patients with psychosocial needs and discharge planning, particularly for complex patients who need long-term acute care.

Before implementing the new system in June 2007, the hospital held 10-minute inservice educational systems to show staff how the system works.

"It's a very simple system but we needed to show what the colors, stripes, and timers mean," she says. ■

(Continued from page 70)

applications for Social Security disability payments and other funding.

Master's-level social workers assigned to each inpatient unit coordinate the discharge plan and start looking at patient resources early in the stay.

"We check to make sure the patients without insurance don't have any other resources forthcoming. If they don't have any potential payers and are eligible for funding, we help them apply," she says.

The social workers identify what patients will need after discharge and work with the family to develop a plan for caring for the patient at home if possible.

"If it's a matter of the patient needing services or equipment that may hold up the discharge, we can complete a brief request for funding," Carroll says.

When patients need to be transferred to a lower level of care, the social workers negotiate with post-acute facilities about taking the patient if the hospital will pay for his or her care for a certain period of time, Carroll says.

"The social workers have a working knowledge of which facilities are able to engage in that kind of discussion," she adds.

Collaboration is key

The social workers often collaborate with other facilities to find the services that patients need in their communities, Cayner says.

One patient, who lives in a rural area, was treated for a broken femur and hip and developed an infected wound at the site of one break. He didn't need to stay in the acute care hospital but needed hyperbaric oxygen treatment for the wound, something that wasn't available in his small rural community.

The social workers found a hospital about 40 miles from the man's house that could provide the service. The University of Iowa Hospital gave the man $40 a week for gas and provided the medications. The other hospital provided the treatment for free.

"This is an example of two hospitals working together to provide services. Almost every facility that we work with understands our program and gives us heavy discounts. Some places take patients as charity cases," Cayner says.

When patients need post-acute care, the social workers identify the patient's post-acute needs and develop a list of potential providers in their area from which the patients can choose.

"We ask them for their preference in placement but warn them that their preferred facility may not respond positively to taking someone who is without funding. We try to be realistic and keep them informed of the issues in regards to placement," Carroll says.

Patients who have been severely injured and have intensive post-discharge needs post the biggest challenge, Carroll says.

"Patients who are cognitively impaired due to brain injuries or alcohol abuse need 24-hour supervision in an assisted living center or home setting. Many don't have social support and no money to pay for home care but don't qualify for residential programs. Those are the people who fall through the cracks," Carroll says.

These patients have no financial resources and are using a large amount of hospital resources but the hospital can't discharge them without a safe plan, she points out.

"The social workers get very creative on the inpatient level. If may be a combination of providing physical therapy and occupational therapy here so they can achieve a minimal level of function that enables them to be discharged to another level of care," she says.

For instance, one patient with no social support and no funding had a traumatic brain injury, a history of alcohol abuse, and needed assistance with his activities of daily living. After a course of therapy in the hospital, the social worker was able to find a placement for him in a group home for people with a mental health diagnosis.

In the case of homeless patients who need home health services, the social workers often are able to negotiate with a homeless shelter to allow the patient to stay during the day. They can arrange for visiting nurses funded by the county to take care of the patient's needs.

The hospital is seeing an increasing number of patients who have cognitive impairment and need the equivalent of a baby sitter during the day.

"We always look at family resources first. That tends to be what patients are most comfortable with and it eliminates us having to use outside funding and resources. Family members may want to help but they live in another community or work full time. It's hard to find families with someone home during the day," she says.

*(Editor's note: For more information, contact **Jill Carroll**, social work specialist, University of Iowa Hospitals and Clinics, e-mail: jill-carroll@uiowa.edu.)* ■

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Caring for behavioral health patients in the ED

Hospital to 'create windows' for frontline providers

Behavioral health patients are put at risk if the players coming to the table are not coordinating efforts to make the most efficient use of available resources, notes **Mark Catalano,** LCSW, manager of admissions at Seton Shoal Creek Hospital in Austin, TX.

Factors that typically challenge that process, he adds, include a lack of readily available psychiatric expertise and communication barriers among caregivers.

At Seton Shoal Creek Hospital and in the city of Austin as a whole, Catalano says, health care leaders are looking at a multifaceted solution involving a mobile assessment team, telecommuting, standardization of tools and data tracking, and enhanced cooperation and communication between psychiatric hospitals and the emergency department clinicians who send them patients.

Part of the focus at Seton, he explains, is on "trying to create windows so that ED physicians and social workers know our capacity, what kind of patient is best for us, and which patients go on which unit." It's crucial not only to let them know what's available, Catalano points out, but to realize that each facility has its own way of describing patients.

Seton Shoal Creek uses a standardized risk assessment tool on every patient, including those in inpatient units, Catalano notes. "What we need from the ED [caregiver] is how high the risk is for that patient."

The number derived from the assessment determines whether and where the patient will be placed at the facility, he adds, but often the ED clinician is "not speaking the same language" as staff at the psychiatric facility during the assessment process.

In many cases, Catalano says, the patient in question has been to Seton Shoal Creek before. "We may have seen the patient 10 times, but he or she is new to ED staff and they describe the patient in a way that conflicts with our experience."

A behavioral health patient who presents at the ED "may be at the baseline for him or her," he adds, "but the ED [care provider] thinks the person is out of control." With accurate communication, Catalano says, "we may be able to say, 'Oh, that patient is just coming in to get a meal,' and give them suggestions on how to handle the person."

With such issues in mind, Austin's behavioral health leadership is working to standardize the assessment process across the city, Catalano says, "and see if we can agree on a core set of assessment tools, such as CIWA [Clinical Institute Withdrawal Assessment], CINA [Clinical Institute Narcotics Assessment], neither of which is used by any of the EDs, and a suicide or homicide/aggression assessment."

The implementation of such tools, he adds, will require education for ED nurses and social workers.

A pilot program started at Seton in July 2007, Catalano notes, focused on training social workers throughout the hospital network.

"We brought in all of our on-call social workers for the network — those who work all night — and educated them on our internal assessment forms so they could do our assessment for us," Catalano says.

When presented with data "on forms we recognized and used, with scores we would use internally," he adds, Seton personnel "know we can trust that [information]."

The payoff carries through to the utilization

review piece of the process, Catalano notes, "when from the beginning we get good documentation."

Also under way, he says, is development of a software-based database that would allow "all the players — the ED, the emergency medical services, and the behavioral health hospitals — to share information."

That information would be available, for example, when a patient presents to the ED or is en route to the hospital with an overdose, Catalano adds. With standardized data in one system accessible to all, he says, caregivers can check to see if and where appropriate beds are available for the patient.

With initial responders using the standardized screening tool, Catalano says, "Austin's two private psychiatric hospitals could quickly respond to an alert on a patient needing care with, for example, 'We've got a Level 12 bed on this unit, and it looks appropriate.'

"What EDs want from us is for us to pull patients rather than them having to push them," he points out, "and the more we can trust the form and the language, the more we can do that."

In the past, behavioral health providers tended to have an adversarial attitude toward the various EDs in town, Catalano notes. "We realized that we were looking at EDs as the enemy, feeling they were trying to dump patients or not give us all the information and [cases would be] different from what was presented on the phone."

The reality, however, is that the EDs "are our customers — the front line that finds patients for us," he says. "We've tried to [shift] our thinking and say, 'What do we need to put in their hands so they are better able to deal with the patient and can become our best sales force?'"

Seton Shoal Creek was on track to develop a mobile assessment team for behavioral health patients, Catalano notes, but it now looks as though the city of Austin — with matching in-kind contributions from the hospital networks — will take leadership of that project.

The idea, he says, is for caregivers to load information into a citywide system while observing a patient on-site.

"We're looking at putting together teams in which a social worker and nurse would go out and look at the patient, with one psychiatrist assigned to oversee a certain number [of teams]," Catalano explains. "The psychiatrist would be available to evaluate the individual in person if necessary or could use telecommunication to consult on the case."

Personnel for the mobile assessment team would be hired for the city under the auspices of the state Mental Health Mental Retardation department, he adds. The operation would be tied to the state psychiatric emergency services, Catalano says, "which are the 24-7 gateway to the state [behavioral health] hospital or other services."

At Houston's Memorial Hermann Hospital,

CNE *questions*

17. What percentage of the American work force was uninsured in 2006?
A. 10%
B. 15%
C. 18%
D. 21%

18. Audrey Paisley, RN, helps an average caseload of ___ uninsured ED users at Harborview Medical Center establish a relationship with a primary care provider.
A. 90-100
B. 50-60
C. 120-130
D. 20-30

19. An expedited discharge fund helps move patients at University of Iowa Hospital through the continuum of care with its _____ occupancy rate.
A. 98%
B. 82%
C. 80%
D. 75%

20. Peter Moran, RN, C, BSN, MS, CCM, collaborated with other providers to find community resources for a "frequent flier" who visited the ED ___ times in 10 months.
A. more than 20
B. more than 30
C. more than 40
D. more than 50

Answer key: 17. C; 18. A; 19. C; 20. D.

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. ■

where Seton staff made a site visit, a mobile assessment model is in place, he notes. "A medical director is paid to be available and is on-call if the nurse or social worker on the team goes out and needs the physician piece."

The psychiatrist participation is "more to help smooth things out with the ED physician if the social worker is recommending something and the ED physician is not in agreement," Catalano says. "The trust factor is a barrier."

Houston is "a year or two ahead on the [telecommuting] curve," he adds. "It's another option for the mobile assessment team if they can't get to the facility across town in a timely fashion. Depending on the level of need, the social worker might do the initial assessment or the physician on call might do it."

In Austin, Catalano continues, there are plans to use mobile assessment in the same way. Returning to the example of a patient in the ED who has been there all night and into midmorning, he says, if such an individual could be interviewed via telemedicine by a psychiatrist or other behavioral health specialist familiar with his case, a lengthy stay and possible admission may be avoided.

"This is a way to reach out into the front line and add our level of expertise," Catalano says. "We see these kinds of patients day in and day out."

A behavioral health call center has a vital part to play in facilitating the treatment of a psychiatric patient who presents at the ED, notes **Sue Altman**, president of the Phoenix-based Call Center Consulting Network.

"The ED is really set up for medical patients and typically is already overcrowded," adds Altman, who offers strategic planning and positioning services for call centers. "Behavioral health issues are usually not dealt with very quickly in the ED. The last thing you need is somebody having a meltdown."

ED clinicians, of course, do a screening as quickly as possible to determine if there is a medical issue, she says. "If there is an overdose, obviously they would process that and, if necessary, admit the patient to a [nursing] floor."

However, a situation in which someone appears to be disoriented, with homicidal thoughts, auditory hallucinations, or delusions, Altman says, "is usually not something an ED physician is comfortable assessing."

In such cases, she continues, ED staff would contact the call center, "which would get someone there to assess patients and get them on their way to the right destination for care, including [arranging for] some kind of transportation, often an ambulance."

That could mean mobilizing a social worker who is in a different part of the hospital, she says. "Case managers may be trained to do these quick assessments if need be."

If the facility is part of a system of hospitals and the necessary resources are not available at that location, Altman says, call center staff may call on one of the system's behavioral health professionals who may have to drive there quickly.

"They will do an assessment," she explains, "and typically call the call center back because it is arranging bed availability." Call center staff, Altman adds, "would know if the behavioral health facility or state hospital or psychiatric emergency service — which is like a big psychiatric ED — has a bed."

These psych EDs can hold a patient for 23 hours, but don't have inpatient facilities, she notes. "When patients present at the ED with bipolar [disease] or other conditions, in most cases, if they can be started on meds, within 23 hours — the length of time they can be held for observation — [staff] can have them under control and they can go home, with some follow-up."

Navigating the system

One of the problems in the behavioral health arena, Altman says, is that people who need the services don't know how to navigate the system. "Psychiatric or behavioral health services are not typically organized to serve an entire city or organization."

In medical care, physician offices are the "feeder system" for hospitals, she points out, but there appears to be a big disconnect between the psychiatric hospital and private practice psychiatrists or therapists.

Even people who have health benefits may not have much coverage in this area, Altman notes, and "there is a big movement for therapists not to accept insurance at all."

"[A condition] that may have been nipped in the bud if the patient had talked to someone at the primary care level may get really out of control before a family member [intervenes]," she adds. "If these people can't afford care or don't have resources or fear the stigma, they may lose their job and alienate from the family before it's obvious they need care badly."

The nation's uninsured population is another growing crisis, Altman says, which "hurts on both the medical and psychiatric side."

In two or three cities where Altman is working on call center strategies, she adds, private and governmental behavioral health providers are joining forces to look at solutions to the breakdown in services.

"What they recognize is they're all seeing the same patients, and end up just trading them," Altman points out. They may receive inpatient care, she says, "but once they return to their lives, if they can't get in to continue management with a psychiatrist, you're really just putting them right back in the same situation."

Efforts under way to centralize and track data, Altman says, are designed to answer questions such as, "Are [providers] seeing the same 100 patients or are there really 1,000 patients?"

"We know how many go through each of the [organizations] — they all have the counts — but until we look at the data level, we won't see that Jane Smith has visited all of us in the past month," she adds. "It could look like 1,000 people need services, but it could be the same 400, coming two or three times a month."

*(Editor's note: **Mark Catalano** can be reached at mcatalano@seton.org. **Sue Altman** can be reached at sue.altman@3cn.org.)* ■

'One-stop connection' gets technology boost

Call center coordinates psychiatric services

A major software upgrade has dramatically increased the ability of a New Jersey health system's behavioral health call center to serve as a "one-stop connection" for local emergency departments, psychiatric emergency screening services, and a stand-alone psychiatric hospital, says **Dawn Fenske**, director of Saint Barnabas Management Services in Toms River, NJ.

The call center is "customizing screens, creating reports, and converting all of our data from the old to the new software" since going live with the behavioral health component of a software program already in place on the "concierge" side of the operation, Fenske adds.

The concierge center, she notes, handles physician referral, class registration, and other nonclinical services for Saint Barnabas HealthCare System, while the behavioral health side coordinates the care of psychiatric patients across the Livingston, NJ-based system.

"We make sure the client has medical clearance, has all of the prerequisites for inpatient admission, has all paperwork completed, and that signatures are [obtained] if it is an involuntary admission," Fenske says. "If legal [counsel] is needed, we make sure it's involved. We act on behalf of both the patient and the facility."

Once the call center has all the information, she adds, "we call the unit, tell them patient so-and-so is coming in and the estimated time of arrival, and make sure there is a bed for the patient."

With the new software, Fenske says, "We were able to write our own guidelines for behavioral health — more or less a checklist of the needs and requirements at different levels of care. It pretty much creates a medical record, which is sent as a report electronically to whatever level of care the patient is admitted."

*(Editor's note: **Dawn Fenske** can be reached at dfenske@sbhcs.com.)* ■

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