HOSPITAL CASE MANAGEMENT™

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

AHC Media LLC

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Show value of your case management department to justify adding staff

Case managers often asked to do more than they can handle

Most case management departments need more staff to adequately perform their duties — but how do you justify it to a hospital administration that is pinching pennies just to stay afloat in today's tightening health care marketplace?

Case managers have to make the business case for hiring more staff; that means tracking what you do every day, determining the impact that case management has on financial health of the hospital, and creating reports to show to administration, says **Toni Cesta**, RN, PhD, FAAN, vice president, patient flow optimization for the North Shore-Long Island Jewish Health System and health care consultant and partner in Case Management Concepts LLC.

Case managers often are called on to take on additional tasks "because they're in the charts already," but it can get to the point that case managers are asked to do much more than they can handle in a day, she says

"The more functions you give a hospital case manager, the fewer patients she can manage. Taking on more and more and not being able to adequately complete the work taken on is not positive for the department, or the organization," Cesta says.

Making the case for more FTEs

"Data have helped us demonstrate to the hospital administration what we are producing for our FTEs. Tracking a wide range of data is critical when it comes to explaining how case management contributes to the hospital's overall objectives," adds **Judy Milne**, RN, MSN, CPHQ, director of integrated case management and quality improvement at Sarasota (FL) Memorial Hospital.

Having strong data to show the value of case management has helped Milne keep her staffing stable for the past five years.

However, she adds, "when times get really tough, it's not going to matter. If the whole organization is struggling, we will have to reduce staff regardless of our data."

The case management department at DCH Health System in Tuscaloosa, AL, recently added four 0.7 FTEs to the staff at its two largest hospitals, says **Brian Pisarsky**, RN, BS, ACM, CPUR, director of case management services at DCH Regional Medical Center and DCH Northport Medical Center

"We try to find a way to measure everything we do to show the value of interventions by the case managers," says Pisarsky, who provides administration with monthly reports that include dollar amounts for case management interventions. **(For details on DCH Health System's case management value measuring system, see related article on p. 116.)**

When Southern Ocean County Hospital in Manahawkin, NJ, developed its case management program, **Marilyn Butler**, RN, MSN, CCM, director of case management, was able to supply data that helped her to get her administration to agree to keep caseloads at a maximum of 15-16 patients.

"At our hospitals, case managers see 100% of the patients, and they review every patient every day, including Medicare patients. In addition to handling the utilization review piece, they are involved in discharge planning activities such as setting up post-acute services; they track measures and work with the quality team on quality issues," she says.

Other departments have cut staff in recent months, but so far Butler has kept all her case managers.

Where documentation improvement fits

Now that the Centers for Medicare & Medicaid Services has implemented the new severity-adjusted MS-DRG system, hospitals must have a documentation improvement program, but it's not something that can be added to a case manager's daily workload, Cesta says.

"The severity levels in the MS-DRG system are significantly different in terms of dollar reimbursement, but the volume of work is untenable for case managers to take on," she says.

Case management directors may be able to justify the additional FTEs for a documentation improvement project by demonstrating the increase in the case-mix index.

"With the severity-adjusted DRGs, hospitals can't afford not to do it. When a case gets coded into a lesser DRG, it can mean a significant reduction in dollars," Cesta explains.

When you approach your hospital's administration to make a pitch for more staff, keep in mind that the administration may not completely understand what case managers do, Cesta cautions.

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You may need to explain the roles of your department before you make the case for more staff. **(See related article, right.)**

Track data to make case

If you don't think you have enough resources to do the job your department is charged with, collect data and use those to justify more staff, Milne advises.

Take your list of case management functions and determine the time frames in which each role and set of functions must be performed. For instance, reviews may have to be completed by noon each day or discharges must be expedited for a 10 a.m. discharge time.

Then perform a time and motion study to measure case management productivity. Start by determining the average number of reviews done each day by each staff member. Then determine the average length of time it takes to complete each review, Cesta suggests.

For instance, before approaching administration on a final case management model at Southern Ocean County Hospital, Butler conducted a pilot on the telemetry unit in which the case managers tracked the time it took to complete each task they did every day.

Butler created a sheet on which case managers entered the patient name or medical record number and wrote down the time they started a review and the time they finished it. They tracked the time it took to get authorization from a managed care company and the time it took to order equipment or set up home care or fax information to the nursing home.

"We tried to capture every minute they were involved in something. Any case manager can tell you that one case could take you all day if it's complicated and the family is involved. We wanted to get down on paper how hard our case managers work and how long it takes for them to do their jobs well," she explains.

Butler suggests having your case manager time everything he or she does every day for at least a week. "Every day is different. You need to track case management time for at least a week and come up with an average," she says.

You may be able to use your data to show the relationship between the shortage of staff and the bottom line of the organization, Cesta points out

"If the data demonstrate the negative quality or financial impact of the department's inability to successfully complete all it has to do, case management directors can use the information to make the case for more staff," Cesta says.

For instance, track the amount of time it takes for case managers to review a patient admission and compare it to the number of admissions and the number of case managers on staff, Milne suggests.

You may be able to demonstrate that, with the staff you have, you can review only a certain per-

Making your case

Explain roles, measures that affect caseload

In addition to giving your administration a list of roles, provide specific and detailed definitions and outline the functions your department performs for those roles, says **Toni Cesta**, RN, PhD, FAAN, vice president, patient flow optimization for the North Shore-Long Island Jewish Health System and health care consultant and partner in Case Management Concepts LLC.

For instance, your department may be responsible for utilization management but senior management may not know what that job specifically entails, she points out.

"List the specific functions your department performs under the role of utilization management, such as insurance reviews, concurrent and retrospective appeals, determining levels of care, and so on," Cesta says.

Determine who performs each role, whether it's a nurse case manager, a social worker, an appeals manager, or the director of the department, she says.

Optimal caseloads will be affected by your model design and the various role functions of the case managers.

Case management caseloads may be affected by staffing patterns, patient complexity, intensity of service, payer mix, length of stay, and use of technology, Cesta says.

If you have a higher percentage of patients covered under managed care, you're likely to be doing more reviews. If Medicare makes up a higher percentage of your patients, they're likely to need more complex discharge planning. A high percentage of Medicaid patients means more psychosocial issues to handle.

Length of stay can be a double-edged sword, Cesta points out. A shorter length of stay means a faster turnover and a shorter time to take care of patients' discharge needs. A longer length of stay typically means patients need more complex discharge planning. ■

centage of admissions.

Then determine what percentage of the cases that were reviewed were inappropriate admissions that the case managers were able to avoid.

How staffing could affect admissions

Use those data to show how many inappropriate admissions the hospital could avoid if you had enough case managers to review every admission.

"It is critical to keep an ongoing case management report card that demonstrates which areas of the organization are impacted by case management roles and functions and provides a barometer of how the department and organization are doing," Cesta says.

Select quality and financial metrics to track since case management affects both, she says.

Examples of financial metrics may be denials and appeals, excess and avoidable days, inappropriate admissions, observation hours, and short stays. Whenever possible, include the dollar impact associated with the case management interventions, Cesta says.

Include cost avoidance examples in your report, she suggests. For example, determine the number of inappropriate admissions you diverted from the ED. Follow the cases you affected for expedited discharges. Show how many avoidable days were prevented through your case management interventions.

At Southern Ocean County Hospital, the case management department keeps track of avoidable days and denials and uses hospital information system data to put a dollar amount to how much they have saved.

Using the data Butler compiles, the vice president of medical affairs gives individual physicians a report card with details of how much they cost the hospital by denials and avoidable days.

The case managers track any time they can expedite a discharge that is being held up pending a test or procedure or get the physician to agree that the test can be done on an outpatient basis.

"We try to save the hospital as much money as possible, but they have to know that we are saving money. That's why these reports are so important; you have to toot your own horn," Butler says.

Milne tracks case management outcomes including length of stay, denials, observation vs. inpatient status and produces a PowerPoint slide presentation that she reviews with her staff on a quarterly basis.

She tracks a wide range of data that include case management process data, avoidable days, denials and those the financial case managers successfully appeal, and statewide statistics that relate to case management.

Milne shares the data in the hospital's weekly patient flow meeting attended by the CEO, the chief nursing officer, nursing, and ancillary department representatives.

"I use every opportunity to share our data at random meetings when length of stay or denials are discussed. I want to make sure that people are aware of our key statistics and are aware that case management is driving them," she reports.

*[For more information, contact: **Marilyn Butler**, director of case management, Southern Ocean County Hospital, Manahawkin, NJ. E-mail: mbutler@soch.com; **Toni Cesta**, RN, PhD, FAAN, vice president, patient flow optimization, North Shore-Long Island Jewish Health System. E-mail: tcesta@lij.edu; **Judy Milne**, director of integrated case management and quality improvement, at Sarasota (FL) Memorial Hospital. E-mail: judy-milne@smh.com.]* ■

Want more FTEs? How to state your case

Hospital system measures value of CM department

At a time when case management departments all over the country are facing cuts in staff or just remaining stable, DCH Health System in Tuscaloosa, AL, recently added four 0.7 FTEs to the case management departments of its two largest hospitals.

The new staff are clinical documentation specialists who handle clinical documentation review and are now taking on the job of concurrent reviews for the Centers for Medicare and Medicaid Services' core measures quality reporting initiative.

Brian Pisarsky, RN, BS, ACM, CPUR, director of case management services at DCH Regional Medical Center and DCH Northport Medical Center, attributes the increase in staff to an extensive data tracking system that measures case management interventions, adds up their value, and creates a monthly report for the

hospital's administration.

"If you can justify and show the value that case management brings to the table, you can get the staff you need. But you have to have specific data in order to be able to justify it. We apply dollars to every single category of case management interventions. We let the administration know that if we weren't here and were not able to intervene, at minimum, this is how it would affect reimbursement at this hospital," he says.

Pisarsky's department performs multiple monthly audits to ensure that the hospital is compliant. These include one-day stays, patient choice, three-day qualifying stays, readmissions, MS-DRG pairs, and accuracy of documentation.

"We never compromise the care of the patient. We continually strive to find ways to positively impact the care of the patient while monitoring the financial impact of our processes," he adds.

DCH Regional Medical Center is a 580-bed regional facility that receives referrals from seven counties. DCH Northport Medical Center is a 204-bed acute care hospital with both inpatient rehabilitation and psychiatric specialty units.

Case managers are in charge of care coordination; creating the discharge plan; and utilization review for Medicare, Medicaid, and self-pay patients. They are unit-based and have an average caseload of 24 patients.

The 53 employees in the case management department at both campuses include utilization review coordinators who handle commercial utilization review, social workers, infection control, a hospital-to-home case manager, clinical documentation specialists, and two nurses who handle inpatient and outpatient denials and appeals.

Tracking progress

As one way of tracking its progress, the department develops goals for each year and monitors them on the case management software system's electronic dashboard.

"Everyone in the department is aware of our department goals, what we are measuring, and our progress toward meeting each goal," Pisarsky says.

For instance, each year, the team looks at the percentage of patients in observation status compared to the same time frame the previous year and sets a goal based on those data and national standards.

Among the department's other goals listed on the dashboard are the case-mix index, the base-mix index, the average length of stay for all patients, the length of stay for patients transferred to skilled nursing facilities, and the length of stay for patients being discharged with home health.

If the goal is being met or exceeded, the dashboard is green. If it varies by 5% either way, it is yellow. When the department fails to meet its goals, the dashboard is red.

Data are available through the computer system and a printout is given to all case managers every month.

The hospitals use an electronic case management system, which, in many cases, can automatically calculate the revenue generated by the case management intervention when the case managers enter it on the wireless laptop computers they take with them as they complete their work.

Pisarsky uses the data to create monthly reports that he shares with the administration.

"One of the most important things the case management directors can do to prove the value of the department is to apply dollars to what the case managers do," he says.

For instance, to demonstrate the value of the work of the clinical documentation specialists, the department measures the capture rate of complications and comorbidities (CCs) and major complications and comorbidities (MCCs) in the MS-DRG system and computes how many CCs or MCCs are added after the clinical documentation specialists review the case with the physician to make sure the documentation is accurate and complete.

By comparing what the physician originally wrote in the record with documentation that was added after the case management query, Pisarsky is able to demonstrate the increase in reimbursement due to case management efforts.

"We compare the original MS-DRGs based on original documentation with the MS-DRG after we intervene and tabulate the difference in reimbursement. This is entered into a spreadsheet that is part of the department's monthly report to the administration and the entire case management department. Some queries do not influence reimbursement but the documentation specialists make sure that all documentation is accurate and complete," he says.

By tracking the response rate to queries from physicians and the number of queries issued by case managers and comparing the data to previous months, Pisarsky can determine that the case managers are querying the physicians appropriately and are getting answers to their queries.

The department measures both the case-mix index and the base-mix index at both facilities as part of its efforts to document case management's effect on the bottom line.

The base-mix index is made up of all the medical MS-DRGs and excludes surgery and other hospitalizations that do not involve medical illnesses.

"The case-mix index includes all admissions and can be dramatically influenced by the number of surgeries the hospital performs each month. Case managers can't impact the number of surgeries, but with medical admissions, they can make sure the medical record captures all the documentation necessary for the CCs and MCCs that show how sick the patients really are," Pisarsky says.

The case managers review all patients initially placed in observation status and contact the admitting physician if the patient meets inpatient status. If the physician changes the order from observation to inpatient, the additional revenue generated is added to the case management intervention total.

The department also conducts preregistration utilization review to make sure that all patients who come into the hospital for planned procedures are admitted in the correct status.

For instance, the utilization review specialists check to see that patients receiving procedures on Medicare's inpatient only list are admitted in inpatient status. If not, they get the physician to change the status before the procedure is done so the hospital will get paid for the procedure. That amount also is included in the case management outcomes data.

"When our physician advisor works with the admitting physician to expedite a discharge, we count it as nonavoidable day. If the case manager didn't intervene to call in the physician advisor, the expedited discharge would not occur," he says.

The department tracks admission length of stay — the number of patient days divided by the number of admissions in a month — and compares it against benchmark data.

"We also look at length of stay for patients discharged to skilled nursing facilities and home care and benchmark against ourselves because we cannot find other hospitals that track this," he says.

Pisarsky takes the number of patients discharged to skilled nursing facilities and divides it by the number of days. He does the same for home care.

"We want those patients moved to skilled nursing care and home care as quickly as possible," he says.

Hospital-to-home case manager

In fact, the health system recently added a hospital-to-home case manager to make sure that patients who are appropriate for home care receive those services and to find ways to decrease readmission rates, he adds.

The case management department has bimonthly meetings with representatives from local nursing home and home care agencies to discuss barriers to discharging patients.

"We have a continuing process improvement project going on everything we measure," he says.

The department deals with potential denials and appeals both before and after discharge.

Utilization review nurses conduct concurrent interventions with the insurance companies on potential denials.

The department's full-time inpatient appeals nurse reviews all inpatient denials. The denials or underpayments are sent for review and appeal if appropriate.

"If she intervenes, she talks with the nurse or physician at the insurance company and provides clinical information that is beyond the knowledge of the staff in the business office," he says.

The nurse tracks her interventions and their results on a monthly basis and is able to provide a dollar figure on additional revenue the hospital receives as a result of her actions.

"We do exactly the same on the outpatient side. The outpatient appeals and denials management nurse reviews the cases and makes sure we get paid. We measure every dollar generated by these two nurses and report it monthly to the administration and the staff," he says.

Case managers participate in the hospital's weekly length of stay meeting, attended by the vice president of medical affairs and the physician advisor, and share their concerns and challenges with the rest of the staff.

"We discuss every patient who has been here for six days or more and the barriers to discharge. We discuss what issues the case managers are encountering and what they need to be able to intervene," he says.

*(For more information, contact **Brian Pisarsky**, director of case management services, DCH Regional Medical Center and DCH Northport Medical Center. E-mail: bpisarsky@dchsystem.com.)* ■

CRITICAL PATH NETWORK™

Observation unit moves patients quickly through continuum

Patient satisfaction is high, length of stay is short

A 16-bed observation unit has increased bed capacity and improved patient flow at Ingham Regional Medical Center in Lansing, MI.

Before the unit opened at the end of January, the average length of stay for observation patients was 42 hours. After five months, the average observation length of stay dropped to 24 hours and 44 minutes, according to **Sherry Lothschutz**, RN, case manager for the observation unit.

An observation unit creates a win-win situation for the hospital and the patients, **Dennis J. Perry**, MD, MPH, medical director and director of case management and utilization review, points out.

Patients receive the care they need and are discharged home in a timely manner. Hospitals provide high-quality care efficiently and free up inpatient beds for patients who need an acute care stay, he says.

"Patient satisfaction is high on observation units. The majority of people who come to the hospital don't want to stay. They really appreciate it when we focus on getting them expedient care so that their problem is taken care of and they can go home," Perry says.

When observation patients are placed on the floor among patients admitted in inpatient status, the staff on the unit don't always realize that they need to be in and out in a short time and observation patients may end up having two- or three-day stays, he says.

Since reimbursement for observation patients is low, hospitals need to treat these patients efficiently to make sure they get the care they need and are discharged in a timely manner, he adds.

"We are looking closely at cost per patient vs. reimbursement. Even when the hospital gets paid for an observation stay, the reimbursement isn't very high and if the patient ends up having a two- to three-day stay, it costs the hospital money," Perry says.

The nurses on the observation unit know that their patients should be there only 24 hours and see that they get the tests and procedures they need as quickly as possible, he says.

For instance, the nurses in the observation unit don't wait for the laboratory results on their patients to be entered into the system; they mark down a time when the results should be expected, then call the laboratory to get the results. When the results are in, they call the doctor and ask him or her to review the results and write discharge orders if appropriate.

Before the unit opened, the case management team looked at the possibility of flagging observation patients or using different colored charts so that they would stand out when they were on other floors, but decided that an observation unit would be the most efficient way to provide care for patients who don't meet inpatient criteria, Perry reports.

The hospital tried assigning one case manager to review all the new admissions in the hospital for admission status but the system was cumbersome, he says.

"Just having an observation unit where we know the patients' status helps us move them more quickly," Perry says.

The hospital wants to move toward turning the observation unit into a clinical decision unit, he explains.

The 16-bed unit was created from part of the

same-day surgery unit's space during the hospital's recent renovation and expansion project.

Two of the beds in the unit are dedicated to patients who are being transferred from other hospitals. They stay on the observation unit until a bed that meets their needs is available.

The unit also is used for "outpatients in a bed," patients who are hospitalized for a blood transfusion or other procedure, and those who need to stay longer than usual due to complications after same-day surgery.

The goal is to have patients in and out of the unit within 24 hours from admission to discharge, Lothschutz says.

Before the unit opened, the case management team compiled a list of targeted diagnoses that would likely be appropriate for the observation unit and educated the ED and bed board staff about them.

Among the diagnoses on the list are chest pain, abdominal pain, weakness, falls, dehydration, chronic obstructive pulmonary disease, or asthma exacerbation.

Most of the patients in the observation unit come through the ED. Direct admissions from physician offices may be admitted to the observation unit if they don't meet inpatient criteria.

As observation case manager, Lothschutz regularly assesses the charts of all patients in the unit to determine if they should remain in observation or be transferred to inpatient status.

She also works in the ED to determine if new admissions qualify for an inpatient bed or should be placed in the observation unit.

"I work closely with the bed board staff. They are the gatekeepers and the ones who place patients in a bed," Lothschutz says.

The weekend case management staff review patients admitted over the weekend if they have questionable diagnoses.

If a patient being admitted has a questionable diagnosis, the bed board staff contact Lothschutz to review the chart if she is in the hospital. If the patient's diagnosis doesn't meet inpatient criteria, Lothschutz calls the admitting physician and gets an order for observation.

When Lothschutz is not able to go to the ED, the nurse in the bed board department calls the physician for more information, and then reports to Lothschutz.

"We can always change admission status once someone gets to the observation unit, and I can determine if the patient needs to be moved to a full admission," she says.

The unit-based inpatient case managers make new admissions top priority every morning, Perry says.

The goal is to have patients with "soft" diagnoses admitted overnight reviewed before 9 a.m. to determine if they meet inpatient criteria, notes Lothschutz. "These patients have diagnoses like weakness or abdominal pain as an admitting diagnosis. The chart of someone with a heart attack or renal failure is not going to be reviewed immediately," she says.

Shifting inpatient to observation

When the unit case manager determines that a newly admitted patient doesn't meet inpatient criteria, the case manager calls the admitting physician and gets the patient status changed to observation. If the patient is likely to be in the hospital for several hours, the case manager alerts the bed board staff, who move the patient to the observation unit.

"If patients are likely to be discharged within a few hours, when the test results are back, we keep them where they are even though their status has been changed from a full admission to observation. As long as a case manager is involved, we can make a speedy discharge happen on the floor," Perry says.

A big board in the ED lists patients who are going to be admitted and those with admission orders. When she reviews cases in the ED, Lothschutz targets those charts to look for admission criteria.

"If I truly feel this is an observation patient, I can change the status on my own. If I have questions or am not sure, I consult with Dr. Perry," she says.

Lothschutz spends most of her time on the observation unit.

"The reality is I have 13-16 new patients to turn around every day. It's a whole new floor every morning," she says.

Lothschutz often takes care of discharge issues to make sure the patient is discharged from observation in a timely manner.

For instance, a patient from New Mexico with chronic obstructive pulmonary disease was placed in the observation unit when he visited the ED after his portable nebulizer broke and he ran out of oxygen and suffered an exacerbation of his condition. His equipment company didn't provide services in Michigan.

Lothschutz was able to get his equipment company to contract with a local oxygen company to

fill his tanks and get him a nebulizer that plugged into the wall.

"I got everything processed and in the works so he could be in and out on the same day," she recalls.

If a patient comes from an adult foster care provider or a nursing home or is going to need home therapy, she makes sure everything is in place so the patient can be safely discharged from the observation unit.

Lothschutz works closely with the staff from the hospital's psychiatric unit and with social workers to facilitate consults for patients in the observation unit.

(For more information, contact ***Sherry Lothschutz*** *at Sherry.Lothschutz@irmc.org.)* ■

Projects improve patient flow, shorten LOS

Six Sigma initiatives aim to improve processes

Two Six Sigma projects at Wake Forest University Baptist Medical Center in Winston-Salem, NC, focusing on improving patient flow have streamlined the processes for transferring patients from the acute care unit to the inpatient rehabilitation unit and nursing homes.

The first project, designed to improve the process by which patients are referred to acute rehabilitation, cut almost two days from the process.

The second project, which still is under way, aims to improve transfers to skilled nursing facilities.

"We want everybody to be in the acute care setting the appropriate amount of time. Our Six Sigma projects look at the process to identify issues that are barriers to moving patients to the next level of care in a timely manner," says **Patricia L. Mabe**, RN, MSN, CCM, ACM, director of care coordination.

The care coordination department has about 98 FTEs including case managers, social workers, clinical documentation management nurses, and utilization management nurses. The case managers and social workers handle patient flow and discharge planning.

The Six Sigma teams include all appropriate hospital staff for that particular project.

"It's very important to have the staff that does the work involved in the project as we look at every step in the process to determine where the roadblocks are and what we can do to eliminate them," Mabe says.

During the rehabilitation transfer project, the team set a goal of reducing the amount of time the process took from referral to acceptance to rehabilitation.

The team started by mapping the process for admitting patients to rehabilitation and brainstorming on how the process can be improved.

"We decide, as a group, what we can work on now and what will take longer. We've found that it's really important to be focused on what can be controlled," Mabe says.

The team discovered that some patients, particularly those who were not on the trauma or neurosurgical floors, were staying in the hospital after they were medically ready for transfer to rehab. They were delayed because the physical therapy or occupational therapy evaluation had not been completed at the time of the referral.

"Some people were calling the rehabilitation admission consultant at the same time they called for a physical therapy evaluation. Others waited for the physical therapy evaluation to be completed to call the rehabilitation admissions nurse. The goal in Six Sigma is to eliminate process variations. In this case, we got everybody together, looked at the variations in referral processes, and developed a consistent process," Mabe says.

Checklist developed for CMs, social workers

The team developed a checklist for the case managers and social workers that includes obtaining physical therapy or occupational therapy evaluations before calling the rehabilitation admissions nurse to certify that the patient is ready for transfer.

"We have patients all over the hospital who are transferred to acute rehabilitation. The trauma staff and staff on the neurosurgical unit handle so many of these patients that they are familiar with the process. For staff on the general medical and oncology floors, it is very helpful to have the checklist," Mabe explains.

Other initiatives included streamlining the assessment conducted by the rehabilitation admissions nurse and changing the sequence in which the insurance companies received information needed to certify the rehabilitation transfer.

Now, instead of waiting for a physician to sign a discharge order, the department requests certification from the insurance company as soon

as the rehabilitation admissions nurse completes the evaluation.

Another Six Sigma team is working on a project to reduce the length of stay for patients who are being transferred to skilled nursing facilities.

"We know that our length of stay for these patients is longer than expected. Our project is focusing on why these patients are staying longer and eliminate the barriers to transferring them," Mabe says.

A team that includes case managers, social workers, unit nurses, and physicians examined data from the general medical population and determined that many of the patients with longer than expected stays were being treated for urinary tract infections and they were staying longer because the final results of urine or blood cultures were not available.

When the project began, the laboratory was reading all the urine cultures in batches. Simply changing the process so they read the oldest cultures first helped get the treatment team the data they needed to discharge the patient in a more timely manner.

"This simple process change came from having data and knowing where to look," Mabe says.

Other patients were staying in the hospital because the discharge summary for the nursing home was not ready.

The team has worked with the physicians to see that the majority of the discharge summaries are completed the day before the patient is expected to be discharged, rather than after the discharge orders are signed. Now, they add any necessary information on the day of discharge.

"Our physicians are very cooperative, but they are often prioritizing 10 things. We are working to help them understand that sometimes what we need to facilitate a discharge is important to patient care. If they don't complete the discharge summary, it will delay things in the end. We need patients to be discharged so that patients waiting for a bed may be moved. It's a domino effect that impacts the entire hospital," Mabe says.

The team brought in nursing home and ambulance service representatives to brainstorm on solutions to problems with transfers.

"We listened to their challenges and talked them through. With each of the little fixes, we tried to have all of the stakeholders' needs addressed. We looked at what we could do to help address the challenges they face," Mabe says.

Since there only is one ambulance company that transports nonemergent patients, waiting for transportation was holding up patient transfers.

For instance, ambulance company representatives told the team that it couldn't handle a lot of requests for patient transports late in the day.

Among the solutions was to alert the ambulance service as soon as the physician says a patient is likely to be ready for discharge and the facility has a bed and get that patient on the ambulance company's pending list.

The skilled nursing facility representatives reported that discharges late in the day created a challenge for their staff who had to stay late to complete the admission paperwork.

"We are trying to get them the information about the patient as soon as we have it. If they have the discharge summary, they can order the drugs that the patient will need and have them on hand when the patient arrives," Mabe reports.

The team also tackled ways to cut down on delays caused by family resistance to transferring their loved one to a nursing home.

"We have a very short window of time because these patients are typically in the hospital less than six days. We don't want to push them. We try to educate them and let them know the anticipated time frames so they don't expect for the patient to stay in the hospital until they can decide where the 'perfect' place will be and so they will have multiple opportunities to have their questions answered," Mabe says.

One tactic is for physicians to tell the family in the beginning when they anticipate that the patient will have a skilled nursing stay. The idea is reinforced by the staff.

"Patients and families want to hear it first from the physician, not the case manager or social worker. We get everybody on the same page at the beginning so patients and families hear a daily echo of the same thing. As patient advocates, we want the family to hear it often so they have opportunities to have their concerns addressed in a timely manner," Mabe explains.

If family members still are resistant, the team suggests that the family spend 12-24 hours at the hospital taking care of their family member just as they would have to do at home.

"In so many cases, someone has promised their parent they won't ever send her to a nursing home. When they realize how hard it would be to take care of the parent at home, it helps ease the transition," Mabe says.

(For more information, contact ***Patricia L. Mabe****, at pmabe@wfubmc.edu.)* ■

Resource center frees up CMs for clinical tasks

Clerical staff handling faxing, copying

A resource center at Baptist Memorial Hospital-Memphis — staffed by clerical assistants who handle routine faxing, copying, and telephone calls — has helped free case managers to concentrate on the clinical aspects of their job.

"The clerical assistants do nothing independently. Their job is to take care of paperwork and other details so the case managers and social workers can concentrate on ensuring that their patients get what they need," says **Randy Brightwell**, RN, BSE, MA, case manager and contact person for the resource center staff.

The resource center recently began handling the hospital's bed express staffed by RNs 24 hours a day, seven days a week. The bed express tracks and places all patients admitted to the hospital, he says.

"Previously, the facility has spent many days in what we call 'red status,' which means we are holding patients in the emergency department or post-anesthesia care unit. The resource center's primary function is to smooth flow by evaluating all patients in the admission queue and providing for an orderly transition between levels of care," says **Darla Belt**, director of performance review and accreditation.

The resource center opened in October 2007, at the time the case management department was reorganized.

Since the reorganization, the average length of stay has dropped by one day.

"The resource center has been a factor in the decrease in length of stay because the case managers can attend to the kind of clinical issues for which they are trained, instead of spending time on the telephone or faxing. However, we can't take sole credit for the drop in length of stay but we feel that the resource center has been a contributing factor," Brightwell reports.

Baptist Memorial Hospital-Memphis has more than 30,000 discharges a year and more than 50,000 ED visits.

The 706-bed tertiary care hospital has 36 case managers and 15 social workers. Some are unit-specific and others are assigned to major hospitalist groups. Others cover access case management in the ED.

The resource center was developed in response to the hospital's senior leadership strategic initiatives that include improving patient flow and increasing productivity and revenue and reimbursement issues, Belt says.

Belt asked the case managers and social workers to evaluate the clerical duties they were responsible for to determine what could be done by the clerical staff and what had to be done by clinicians, Brightwell says.

"We brainstormed about the development of the resource room and the tasks the staff could do to increase the efficiency of the case managers and social workers," Brightwell says.

For instance, Medicare's patient self-determination regulations require that hospitals give patients a choice of post-acute facilities that will meet their needs.

"This means a lot of copying and faxing to provide patient information to those facilities. We determined that the case manager should direct what information should be provided to which facilities but the clerical staff could do the copying and faxing, freeing up the case managers to spend more time with the patients and families," he says.

The team looked at insurance company precertification requirements and determined which tasks could be handled by a clerical person.

For instance, some insurance companies require that an intake person assign a case number and then refer the precertification request to a case manager for review. With other companies, a precertification call goes directly to a case manager.

"When we analyzed this, we determined that it was a waste of time for case managers to talk to the intake person to establish the case. We moved that task over to an assistant. They contact the insurance company by telephone, fax, or e-mail, depending on the insurer's preferences, to establish the initial notification for referral to an insurance case manager," Brightwell says.

The resource assistants notify insurance companies about the admission of patients who have secondary Medicare coverage, such as private HMOs that provide Medicare Advantage coverage.

"If it's a plan that requires clinical information, the assistants don't get involved except for faxing the information," he says.

Information on the patient is entered into the hospital's electronic case management system by the case manager, who is an RN. The assistants in the resource room forward the information to the insurance company.

"Assistants in the resource room are not allowed to enter clinical information into the computer system. Their job is to take the information entered by the case manager and disseminate it," he says.

Assistants handle IM delivery

The assistants facilitate delivery of the Important Message from Medicare (IM) required by the Centers for Medicare & Medicaid Services (CMS) to notify patients of their rights to appeal their discharges.

The initial IM is given to patients in the admitting department.

As case managers on the floor review their patient admissions, they enter a projected discharge date into the electronic case management system. The system automatically generates a list of anticipated discharges each morning.

A resource assistant compiles the list, informs the case managers of their patients on the list, and assists in serving the letters to the appropriate patients.

When case managers or social workers have clerical needs, they assign the task to the resource center staff through the hospital's electronic case management system.

Since the hospital's patient population comes from a three-state area, the resource center staff provide invaluable assistance in researching post-acute services for these patients, Brightwell says.

"The assistants in the resource room keep up with the post-acute services that are available throughout the area. We are compiling a book of resources, and the assistants are good on the computer, searching for new facilities that may be able to meet our patients' needs," he says.

The resource room staff include four assistants and a secretary who also assists the director. The resource assistants share space with Brightwell, the bed express operation, the director, and the physician advisor.

"I'm the 'go-to' person, and they have other people nearby to turn to if they need help or have questions," Brightwell says.

Assistants must have diverse skills

The assistants come from a variety of backgrounds and have diverse skills, giving them the ability to work as a team and fill all the needs of the case managers and social workers.

For instance, one staff member had worked as an intake specialist in an insurance company and understands how payers operate. Another has a lot of computer experience and skills. The other two already were employed at the hospital as unit secretaries and were familiar with the programs that the hospital uses.

"As we interviewed people, we looked at the skills they had to offer and hired staff with a good balance of skills. Each has their own strengths and can help their peers if needed. We were fortunate that we got a group of well-rounded people who could be cross-trained so they develop new skills," he says.

Each of the assistants has a special assignment in addition to other duties. For instance, one assistant comes in at 6:30 a.m. to compile the IM list and have the documents ready when the case managers arrive. Another works to ensure that all privately insured patients in the hospital have a precertification number to facilitate the billing process.

Others assist case managers with durable medical equipment orders and home health placements; compile the patient log for the in-house skilled nursing facility; work with the bed express to help place patients; and compile data to create reports for hospital revenue and reimbursement meetings and quality reporting.

*(For more information, contact **Randy Brightwell**, case manager, Baptist Memorial Hospital-Memphis. E-mail: randy.brightwell@bmhcc.org.)* ■

ACCESS MANAGEMENT
QUARTERLY

Business center to meld outpatient functions

Clinics affected serve 400,000 per year

Planning is under way for a new ambulatory business center that will consolidate a wide range of outpatient functions at the University of Arkansas for Medical Sciences (UAMS) in Little Rock.

The goal of the new center is to consolidate business functions so that new outpatients will have a single point of contact for scheduling and registration, according to **Philip Baroni**, associate

director for outpatient services.

Imperatives in the plan include:

• Reducing patient frustration with telephone tag and difficulty contacting someone when attempting to schedule appointments at UAMS.

• Reducing the number of calls to outpatient clinics — which serve 400,000 patients a year — that cover an entire range of specialties and are located in multiple sites.

Centralizing the business function in the outpatient environment is a concept that has been under consideration for most of the past 10 years, Baroni notes, but for various reasons has not come to fruition.

UAMS now has 130 front-end staff handling registration and appointments at 30-plus outpatient clinics in a half-dozen buildings, he says. Those functions are accomplished in several different ways.

A unit operating under the supervision of **Holly Hiryak**, director of hospital admissions, currently does preregistration and some insurance verification for 10 of the outpatient clinics and an appointment center serves some of those clinics plus some additional ones.

"Our goal is really to expand those services to cover the gamut [of outpatient clinics]," Baroni says. "The preregistration and appointment groups are really a microcosm of what we want to do with the ambulatory business center."

Streamlining scheduling

Achieving that single point of contact for outpatients will require a cultural change, Baroni says. "The appointment-making process here is done in a variety of ways — the appointment center, the individual physician's office, the clinic — and one of the imperatives is to streamline that.

"Our purpose," he adds, "is to provide excellent customer service by addressing the needs of ambulatory patients in a warm, friendly way."

The initial effort will be with patients who are new to the system, with return appointments continuing to be made in the clinics, Baroni says. "Our goal is to preregister 95% of new patients and to complete any consult or referral obligations prior to the clinic visit as well."

One of the goals is to standardize business processes across the ambulatory clinical enterprise, he notes, and ensure that requirements are consistent in all the clinics.

One of the first steps will be to merge the

CNE *questions*

5. By using data to demonstrate the workload of case managers, Marilyn Butler, RN, MSN, CCM, has been able to keep her case management caseload at what level?

A. 20-25
B. 15-16
C. 18-20
D. 25-30

6. According to Toni Cesta, RN, PhD, FAAN, a high percentage of Medicaid patients means fewer psychosocial issues to handle.

A. True
B. False

7. At DCH Health System, unit-based case managers are responsible for care coordination, discharge planning, and utilization review for Medicare, Medicaid, and self-pay patients. What is the average caseload?

A. 24
B. 16
C. 32
D. 28

8. When Baptist Memorial Hospital-Memphis reorganized its case management department and created a resource center to handle clerical duties often delegated to case managers, the average length of stay dropped by ___.

A. One day
B. 12 hours
C. Two days
D. Eight hours

Answer key: 5. B; 6. B; 7. A; 8. 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 **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

outpatient preregistration unit and the appointment center.

"We are hoping to do this on an FTE-neutral basis," Baroni adds. "We've done some analysis on that."

The intent is to have new patients being served by the ambulatory business center within a year, Baroni says.

Crucial to the process, he notes, is an advisory group of senior physicians that will meet monthly to discuss the project. An operational group made up of "those in the trenches" will meet twice a month.

"We've been presenting the proposal to various physician groups," Baroni says, "and we've had a positive response, but some doubts have been expressed as well."

Once the new ambulatory business center is in place, he explains, the process would work as follows: Someone who needs, for example, an orthopedic appointment — instead of grabbing the phone book and trying to find the right UAMS number — can call the ambulatory business center number for assistance in making an appointment.

Staff will have been trained to make an appointment with a specialist if the patient requires a referral, he says. "If this is a new patient, the employee will do the registration."

Other methods of registration — the Internet or an automated voice response system — that are already being used by the preregistration unit also will be available.

In addition to gathering demographic and insurance information, staff will advise patients of any copays that may be due, he notes. "Ideally, there will be very minimal check-in at the clinic, which will free up clinic staff to focus on the customer service needs of our patients."

*(Editor's note: **Philip Baroni** can be reached at baronijohnp@uams.edu.)* ■

Initial claim accuracy crucial for SSA programs

Impact of baby boomers felt

Make sure you get everything right the first time.

That's certainly not new advice for patient access staff, but in this case it specifically refers to applications made for coverage of patients by the federal disability program.

With the first baby boomers having reached early retirement age in January 2008, the Social Security Administration (SSA), which also administers the federal disability program, is feeling the impact of that "bulge of people," notes **Patti Thrailkill**, director of governmental affairs for MedAssist, an eligibility services vendor.

"Retirement claims have started hitting, and this group is also in their most disability-prone years, so there will be more of those claims coming from baby boomers," she adds. "SSA is absolutely inundated with work."

The agency has been underfunded for 30 years, Thrailkill says, and has 30% fewer employees than 12 years ago.

That's why initial claim accuracy is crucial, she says, and why the hospital's self-pay population must be screened immediately to determine eligibility for the disability program.

Medicaid, which administers the Supplemental Security Income (SSI) part of the federal disability program, pays from the date of application, notes Thrailkill. "Say a self-pay patient meets the eligibility requirements and is allowed under SSI. In order to get the date of service covered, you want the screening process to be such that the patient is screened and the application made on day one."

In addition, she emphasizes, access directors should make sure there is someone at their facility with a basic understanding of the process for filing federal disability claims. That could be a staff member if the claims are handled in-house, Thrailkill adds, or a vendor representative if the job is outsourced.

It also is important that as much information as possible be submitted electronically, she continues. "SSA is rapidly moving to an all-electronic disability claims environment and paper significantly slows down the process."

The Centers for Medicare & Medicaid Services (CMS) "has been beating this drum for many years and some hospitals have picked up on it, but a lot have not," Thrailkill says. Despite the national push for electronic storage of the medical record, she adds, "there are now more providers who have not reached that point than who have."

SSA will send a representative to the hospital to explain the process, Thrailkill notes. "It really is easy once there is an understanding, but there has to be someone at the facility that learns it all."

SSA has employees known as professional

relations officers, she says, "who are out there trying to educate [providers] about using [the system] as efficiently as possible."

Her experience, she notes, is that most hospitals are outsourcing the process — whether locally or with one of the national eligibility services vendors — and that there are vendor representatives stationed on site.

In those cases, Thrailkill says, "there is an electronic download every morning [as to] who's been admitted and where they've been admitted. The determination is made then on eligibility for coverage."

In instances where the process is not being outsourced, she adds, "what's probably going on is that there is some awareness that the application needs to be filed and someone will give the patient an 800 number to call."

"As soon as that patient gets out the door after receiving care," Thrailkill says, "getting [the hospital] paid is not at the top of the list. The process is intimidating and not easy to understand.

"For any [provider], how to get self-pay patients covered is a big deal," she adds. "Access folks have a lot to do with screening and the direction that paperwork will go. They need to jump on this right away."

The more help that is provided to the patient, the better, Thrailkill notes, and the quicker the process will go. She advises access staff to take these steps to facilitate the claim:

- Electronically transfer medical records as often as possible.
- Provide upfront medical records on the most severely medically compromised patients.
- Provide medical records on long-term inpatients.

It's more important than ever before that access staff make the effort to obtain federal disability coverage for their patients, she says. "State Medicaid programs are drying up and local and state programs don't have the kind of money the feds do to improve the situation."

*(Editor's note: **Patti Thrailkill** can be reached at pthrailkill@medassistgroup.com.)* ■

Which states get good grades for kids' health?

A report released by the Commonwealth Fund ranked hospitals in 50 U.S. states and Washington, DC, on the value of the health care they provided to children. Iowa and Vermont came in at the top; Oklahoma and Florida fared the worst.

Hospitals were judged on: health care access, quality, cost, equity, and the potential for kids to lead long and healthy lives. Also rated were rates of insurance coverage, vaccinations and preventive visits to doctors, among other issues.

States in the top quartile were Iowa, Vermont, Maine, Massachusetts, New Hampshire, Ohio, Hawaii, Rhode Island, Kentucky, Kansas, Wisconsin, Michigan, and Nebraska. ■

AHA honors four hospitals for volunteer programs

The American Hospital Association (AHA) honored four hospital volunteer programs with the Hospital Awards for Volunteer Excellence (HAVE).

Winners fall into four categories: community

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. ■

COMING IN FUTURE MONTHS

- Coordinating care through the continuum
- Why documentation assurance programs are more important than ever
- Finding resources for the uninsured
- Tips for complying with Medicare regulations

service programs, inservice hospital volunteer programs, fundraising programs, and the positive impact their contributions have had. The winners are: community service programs, VA Puget Sound Health Care System in Tacoma, WA; inservice hospital volunteer programs, Alaska Native Medical Center in Anchorage; fundraising programs, Mercy Medical in Daphne, AL; and community outreach and/or collaboration, Intermountain Healthcare in Salt Lake City. ■

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