

**Case Management Managing Access  
Protecting Hospital Resources and Patient's Benefits**

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Appropriateness of hospitalization and the utilization of inpatient and/or observation care is under the microscope of payers, both government and commercial, in attempts to confront the growing cost of healthcare; for payers and providers. A hospital bed is a precious commodity and, equally challenging, access to these beds in a timely manner has become a source of stress for hospitals who are struggling with capacity issues.

A strong case management program will ensure that all patient access points have appropriate mechanisms in place to provide surveillance for medical necessity, but also offer patient centered support in evaluating the patients' needs and, if hospitalization is not needed, work with patients and families to offer alternative solutions.

Where are the access points? For many Case Management Departments, the emergency room has become recognized as an essential in staffing plans as well as recognition of the importance of a dedicated team for evaluating admissions and ensuring appropriate discharges along with social work partners managing crisis and frequent utilizer. However, the *other* access points have not been as prominent in the recognition for oversight.

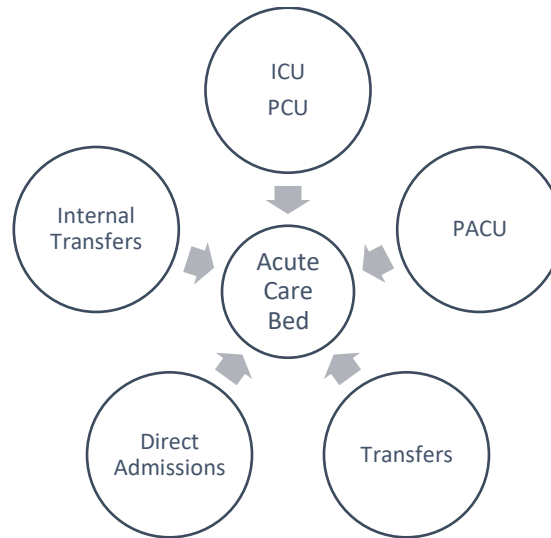
Access to care inside the hospital is reflected in 3 types of status and 4 entry points (5 including internal transfers). A patient can be identified as an inpatient, an observation patient or an outpatient (in a bed). Case Management, with the aid of evidence-based tools and criteria, is widely recognized as the authority in determining appropriate status and has garnered support and strong clinical partnerships with physicians during the admission decision making period.

To better understand the significance of Access Point (entry point) surveillance, it is important to identify where they are:

Emergency Department	Scheduled Admissions	Transfers	Direct Admissions	Internal Transfers
Patients who present in the emergency department for care and later determined to need a hospital bed	Patients who have been scheduled for surgery or a procedure (which can also be recurring) ✓ Outpatient Surgical Cases and the PACU	Admissions requested by other hospitals who do not have available resources for the patients level of needs	Patient's referred from an outpatient site such as Primary Care Clinics, Specialty Practices and other outpatient centers	<ul style="list-style-type: none"> <li>• Acute to ICU</li> <li>• ICU to Acute</li> <li>• ICU to Step Down</li> <li>• Wrong Acute Bed</li> </ul>

The need for a hospital bed must be validated for all patients to ensure appropriate use of hospitalization, the highest cost site of health care. While some areas benefit from full time support, others can be identified through the right triggers and/or partnerships.

In hospitals today the competition for beds is coming from several different sources. This creates an even more critical need to ensure the right patients are in the right bed. Often, the most needed bed is a medical/surgical acute care bed.



### **Functions at the Access Points**

Case Managers must be part of the decision to admit as an opportunity to guide appropriate selection of status for all entry points. However, each entry point has a different approach to this function with specific action items. This includes both the independent identification of patients, to embedding triggers to identify the need for review. Additionally, while Case Management has become widely acknowledged as the expert in status and levels of care, there will be situations when they will need to escalate cases to a physician partner. Having a standardized escalation policy ensures that the efficacy of case reviews are maintained. At the end of this article, you will find a sample escalation policy.

### **Emergency Department**

Today this decision to admit a patient who is in the emergency room is in the spotlight. The ED case manager should be a valued and valuable member of the ED care team. Through use of Evidence based best practice, providing discharge options for physicians, identifying and creating options for high utilizers of ED services and guiding decision to admit processes, the case manager can be critical to the safe assessment and ultimate disposition of the patient to the appropriate level of care.

The evolution of services in the ED, as well as the growing importance of case management has gone hand in hand with the changes in regulations, mandates for access and tight reimbursement. When

positioned correctly, the ED case management can be the driver to positive transitions and financial outcomes.

Case Management must be embedded into the culture of the Emergency Department through creating partnerships with physicians, nurses, and the interdisciplinary team members and demonstrating their value in a patient centered manner. An important tactic for case management is to be present in the geography of the ED. Some CM teams have offices near the ED or in the ED, but rarely come out to round or discuss potential cases with the team. It is important that ED Case Managers consider the patients in the ED as their caseloads, in which screening all for potential needs is a significant function.

ED Case Management is a specialty within acute care Case Managers. This position should be protected to this area as the RN provides services at the hospitals most vulnerable point of care. The Clinical Mindset of an ED Case Manager includes the following:

- ❖ Clinical Knowledge to anticipate the condition and develop a safe plan for either admission or disposition
- ❖ Knowledge of cost and payers
- ❖ Ability to embed the culture of case management and utilization review into the culture of the Emergency area

Case Managers perform both utilization management and discharge planning functions at these entry points in the following manner:

UR Responsibilities	Action Steps	Escalations
<ul style="list-style-type: none"> <li>❖ Medical Necessity Surveillance</li> <li>❖ Evaluation of Status and Level of Care</li> </ul>	<ul style="list-style-type: none"> <li>✓ Participates in the decision to admit process</li> <li>✓ Guides status and level of care decisions</li> <li>✓ Regularly Evaluate boarders</li> <li>✓ If indicated works with payers to authorize care</li> <li>✓ Present ABN's if indicated</li> </ul>	Cases should be escalated to a second level reviewer when the admitting physician is in disagreement with the plan, yet the evidence based criteria does not uphold his/her request
Discharge Planning	Action Steps	Escalations
<ul style="list-style-type: none"> <li>❖ Screens all patients for discharge planning needs</li> </ul>	<ul style="list-style-type: none"> <li>✓ Develops care plans for frequent flier patients</li> <li>✓ Advocates for discharge planning needs</li> <li>✓ Works and refers to social work for psychosocial issues</li> </ul>	Cases should be escalated to a PA when the ED physician will not consider a safe transition plan for a patient as an alternative to an inappropriate admission
Care Coordination	Action Steps	Escalations
<ul style="list-style-type: none"> <li>❖ Follow UP Phone Calls</li> <li>❖ Manages Frequent Flier Care Plans</li> </ul>	<ul style="list-style-type: none"> <li>✓ Contacting high risk patients post d/c from ED</li> </ul>	

## Examples of ED RN Case Management Interventions

A 59 year old with a history of intractable back pain sustained a mechanical fall tripping over a walker 3 days ago. The patient was admitted with an order for social work consult to plan discharge to a skilled nursing facility. If a CM had evaluated the patient in the ED, the patient may have been eligible for a direct admission to acute rehab bed from the ED.

The patient was admitted as an inpatient after complaining of chest pain, diaphoresis, and L arm numbness for two days. The EKG, labs, cardiac enzymes, and d-dimer were normal. Could this patient have been placed in observation status with a stress test planned for the next day rather than an inpatient admission?

A 91 year old female from a nursing home with change in mental status x 2-3 days. No fever, no signs of infection, VSS. Back to baseline in ED. Old aphasia and L sided weakness, consult placed for speech and swallow evaluation. The patient was admitted and fell out of bed on the unit. Discharged the next day. Changed to observation status from original inpatient.

Examples from "Emergency Department Case Management"  
Second Edition

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## Case Management in the PACU

The PACU has become a site in which significant opportunity exists for Case Management support. As outpatient procedures are increasing (that used to be inpatient) the patient population is becoming frailer. In a quest to be patient centered providers are feeling compelled to request an inpatient bed so that the patient can recover longer and under the hospitals watchful eyes. These are patients that are also "unanticipated" in the patient count as they are outpatients. With this population leaking into inpatient beds, the critical need for surveillance has become the demand for several reasons:

- Capacity issues become greater when outpatients are consuming inpatient beds
- Awaiting a bed in the PACU can create bottlenecks or delays in the OR
- The cost of care for these patients can become higher than the reimbursement

Typically, the PACU does **not** need to staff a full time Case Manager, however, providing triggers to the team to ensure guidance with decisions to admit or place in an inpatient bed is a best practice. The opportunity exists to provide support before the decision to move a patient to an inpatient bed exists both before the day of the procedure and after.

## Prior to Scheduled Admissions

### Action Steps

- ✓ Develop and request the surgeon's office to ask high risk questions for patients who are going to have an outpatient procedure. These questions can include:
  - Will you have a caregiver at home for at least 24 hours after the procedure?
  - Are you being treated for depression?
  - Are you someone else's caregiver?
- ✓ Refer those patients that say yes to Case Management for pre-admission phone calls to determine potential post procedural needs and facilitate support

### Possible Action Steps

- ✓ Set up home health
- ✓ Order DME equipment
- ✓ Advocate with family members
- ✓ Set up transportation



## Post Procedure

### Action Step

- ✓ Create a workflow process that triggers a Case Manager (or UM nurse) who works with surgical patients to review non urgent cases prior to transfer based on following indicators:
  - Provider request for an inpatient bed
  - Patient is non-urgent (ie does not need an urgent acute care or critical care bed)
  - Surgical Case Manager is contacted to review record and recommend status **or** Pursue a discharge plan

## Case Management and Transfers/Direct Admissions

It can be quite frustrating and a challenge to capacity when patients are transferred or directly admitted unnecessarily. Case Management participation in decision making, in partnership with patient placement (or bed management) can offer some strategies to manage capacity and ensure the right patients are in the beds.

### Transfers

Patient Transfers should be evaluated to determine whether they are urgent or emergent. In the case of urgent transfers, patient placement managers have the opportunity to pause and ensure appropriateness of the request. Offering patient placement managers light training in status can support recognition of case management guidance.

Additionally transfer agreements for patients are an excellent tool to ensure the patient returns to their home hospital for further recovery. These transfer agreements work best when the case manager is provided this information upon admissions so that they can manage expectations of the patients and referring facility.

## Summary of Action Steps

- ✓ Develop triggers for case management to be notified with unclear transfer requests
  - ✓ CM ensures that the patient meets criteria and is authorized for transfer
- ✓ Train Patient Placement Managers in understanding status
- ✓ Use transfer agreements for repatriation

### Direct Admissions

These patient requests also will flow through Patient Placement, with an opportunity for partnership strategies when the request is unclear or unnecessary. However, unlike some transfers a timely response is critical.

A quick case management response may aide an appropriate decision in these cases and offer visible support to the providers. When the inpatient case manager is helping to manage a patient disposition at their site, they are very grateful!

### Action Steps

- ✓ Develop triggers for case management notification of unclear direct admissions requests
- ✓ Work directly with the provider to ensure an appropriate patient plan

## **Case Management and Internal Transfers**

Case Management can be quite helpful in identifying and proactively encouraging timely internal transfers, specifically with ICU and ED Boarders. With finite ICU beds it is critical that there is capacity for those patients who require this level of care. While not often thought as part of their role, ICU case managers can provide exceptional support in proactively recognizing readiness for transfer either to an acute care bed or out to another setting such as an LTACH.

## SUMMARY

Case Management goes hand in hand with the decision to admit a patient and what status to admit them under. Also hand in hand is the important of physician partnerships. Those physicians that know and understand the regulations surrounding the decision to admit and status to place a patient in are invaluable partners.

Care Management Department  
ESCALATION POLICY

**Policy:** This policy will provide guidelines for progression escalation to leadership in order to resolve issues that create barriers to case management practice in relation to discharge delays or risk in reimbursement or compliance of claims.

**Purpose:** To provide secondary support to the resolution of issues related to care coordination, patient progress, utilization management or discharge delays.

**Process:**

- A. Care Coordinators, Utilization Management Nurses, and Clinical Social Workers will always strive to identify and eliminate barriers to discharge and/or reimbursement at the local level. They will pursue this in the following manner:
  - 1) Ensure early identification of the barrier by early screening, comprehensive assessment and methodical review of medical necessity.
  - 2) Engage the interdisciplinary team in early problem resolutions through patient care meetings, discussions in interdisciplinary team rounds, and meaningful communications with the patient & their support system.
  
- B. In the event, the care coordinator, utilization management nurse, or clinical social worker is unable to resolve at this level, the following guidelines will be pursued:
  - 1) **For patient progression (discharge planning) issues** related to resource needs, delays in internal movement (diagnostic delays, scheduling delays) and delays in post-acute care the following process will be followed:
    - a. Discussion with team lead/educator who will work with the team member to determine leadership point of resolution
      1. Manager (Care Coordination/Clinical Social Work/Utilization Management)
        - Approval of post-acute resource needs under \$1,000.00
        - Conversations with leaders in testing and diagnostic areas to speed up decisions
        - Calls to post-acute care facilities to encourage timely decision making or resolve issues towards making the decision
      2. Director of Care Management
        - Approval of post-acute resources over \$1,000.00 and/or letter of agreements for transfer
        - Conversations with Vice President when barriers to testing and diagnostic issues cannot be resolved

2) **For Medical Decision Making Delays or Conflict in Coordination of Care with Medical Staff,** the team members will resolve in the following way:

a. Credible conversation with the physician discussing the plan for the patient. The following elements should be included in the conversation:

- Knowledge of current care plan and progress of the patient
- Best plan for the patient based on disease trajectory, benefit profile, and psychosocial support
- Pros and Cons of the MD plan

(The team member should never say “what’s your plan”?)

b. If unable to resolve through the conversation, recommend a patient care conference, which all members of the interdisciplinary team meet to discuss and resolve issues. Team member will notify the Manager of their respective area and the Care Management Physician Advisor who may attend this meeting. (Manager is responsible for keeping the Director updated).

c. If unable to resolve, escalate to Care Management Physician Advisor

d. The team member should never wait for Discharge Focus rounds to escalate and issue related to patient progression.

3) **For issues related to admissions decisions** (status or level of care, including transfers out of critical care areas), the team member should resolve in the following way:

a. Notify Lead/educator to help with communications with physician to solve the issue and change orders (if indicated)

b. If unable to resolve, notify/escalate to Care Management Physician advisor.

C. Records should be kept of all interactions and should be documented within MIDAS or other identified systems

1) Issues should be tracked/trended for potential performance improvement initiatives

2) Delays that occur should be recorded in avoidable day reporting

D. Escalation practices and resolutions should be reported at the Utilization Management committee meeting.