

Mastering Utilization Review and Patient Status

a NAHRI virtual event 

Managing Capacity & Reimbursement at the Access Point During and After COVID

Bonnie Geld, MSW

President

The Center for Case Management
Natick, MA

Heidi Rohloff, NP, MSN

Senior Consultant

The Center for Case Management
South Lyon, MI



1

Presented By



- **Bonnie Geld, MSW**, is president and CEO of The Center for Case Management and has more than 20 years' experience in case management with a focus on design of longitudinal case management programs, strategic design and development of transition programs, process improvement, team building, and integration of social work and RN roles. She has been the system director for case management services for a five-hospital system in western Massachusetts, has served as director of care management in Minneapolis and Houston, and has developed and implemented successful care management programs in other states. She has launched a variety of educational programs and workshops on promoting Lean actions, team interventions, rapid-cycle assessments, and integrated care planning.

2

2

Presented By



- **Heidi Rohloff, NP, MSN**, is an acute care nurse practitioner at Ascension Providence Hospital and a senior consultant with the Center for Case Management. As a nurse practitioner and clinical operations leader, Rohloff successfully aligns patient care with administrative and regulatory requirements in dynamic healthcare organizations. In her role as a consultant, Rohloff performs deep analysis on emergency department (ED) assessment and implementation of ED metrics, discharge planning, InterQual criteria for admission status, and high utilizer programs.

3

3

Learning Objectives

- Describe the current urgency to manage quality and financial outcomes in the emergency department (ED)
- Discuss the tools and strategies for case management in their “mission critical” roles

4

4

The Need to Address ED Patient Flow



Quality of care and interventions are compromised



It is costly



ED “crowding measures” are the new metric for CMS



Compromises community trust



Impacts hospital flow

5

5

The ED is the
Only.....

Setting a Patient
Cannot Be Turned
Away From

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay, but since its enactment in 1986 has remained an unfunded mandate.

The burden of uncompensated care is growing, closing many EDs, decreasing resources for everyone, and threatening the ability of EDs to care for all patients.

Emergency physicians provide the most charity care of all physicians (AMA 2003).

American College of Emergency Physicians (ACEP) advocates for recognition of uncompensated care as a legitimate practice expense for emergency physicians and for federal guidance in how to fulfill the requirements of the EMTALA mandate in light of its significant burden on the nation's emergency care system.

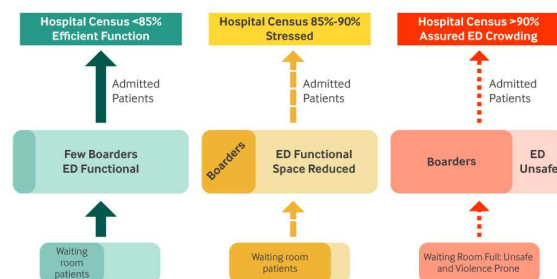
Everyone is only one step away from a medical emergency.

6

Impact of Boarders

Impact of Boarding Admitted Patients on Emergency Department Function

When census is <85%, hospitals typically can function efficiently (green). Hospitals become stressed as census increases beyond 85% and admissions from the ED begin to accumulate from prolonged boarding (yellow) filling the ED to capacity. Most hospitals cannot overcome inefficiencies when hospital census is above 90% (red). The ED becomes overwhelmed and backed up, filling the waiting room and delaying care for those patients leading to increased risk of patient harm.



Source: The authors, based in part on internal Association of Academic Chairs of Emergency Medicine (AACEM) members' data, and informed by Forster AJ, Stiell I, Wells G, Lee AJ, van Walraven C. The effect of hospital occupancy on emergency department length of stay and patient disposition. *Acad Emerg Med*. 2003;10(2):127-133. <https://onlinelibrary.wiley.com/doi/epdf/10.1197/aemj.10.2.127>.

NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

"The impact of ED crowding on morbidity, mortality, medical error, staff burnout, and excessive cost is well documented but remains largely underappreciated."

7

7

Common ED Flow Challenges

There are approximately 20% of patients boarding, at most times, yet there are no proactive practices in place to watch these boarders for potential changes in their status or relief of symptoms to signal a safe discharge.

High utilization of overall resources in the ED. It has been reported that 50% of all imaging procedures are done in the ED. This is in part the appropriate setting for diagnostic workups, but also used as a work around to have diagnostics faster than waiting for outpatient appointments.

Mental health patients waiting medical necessity clearance for a bed

Social admissions and high utilizer patients using the ED as their PCPs or for secondary gains

Bidirectional effect on inpatient capacity

8

8

Case Management/Utilization Review & Social Work

A Mission Critical Strategy

9

ED Case Management/Effective Practice

<i>Utilization Management</i>	<i>Clinical Care Coordination</i>	<i>Psychosocial Support</i>
<ul style="list-style-type: none"> ▪ Guide or be a partner in decision to admit ▪ Guide status decisions ▪ Medical necessity surveillance of boarder patients ▪ Identify opportunities for alternatives to admissions 	<ul style="list-style-type: none"> ▪ Alternative disposition planning ▪ High utilizer interventions 	<ul style="list-style-type: none"> ▪ Addressing social determinants of health to avoid social admissions ▪ Psychosocial interventions ▪ Mental health interventions
<p><i>Anticipated Outcomes</i> <i>Best Practice ED Case Management</i></p>	<ul style="list-style-type: none"> ❖ Lower conversion rates (Code 44) ❖ Lower ED boarder volumes ❖ Decreased readmissions rates ❖ Improvements in ED flow and capacity ❖ Patient satisfaction 	



10

Action Steps

Guide Guide the decision to admit to ensure the right status
Initiate boarder rounds

Identify & facilitate Identify and facilitate opportunities for alternative discharges to avoid unnecessary hospitalization

Develop Develop sustainable discharge plans to reduce high utilizer population

Improved capacity

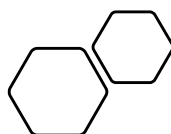
Appropriate reimbursement

Enhanced ED patient flow

11

11

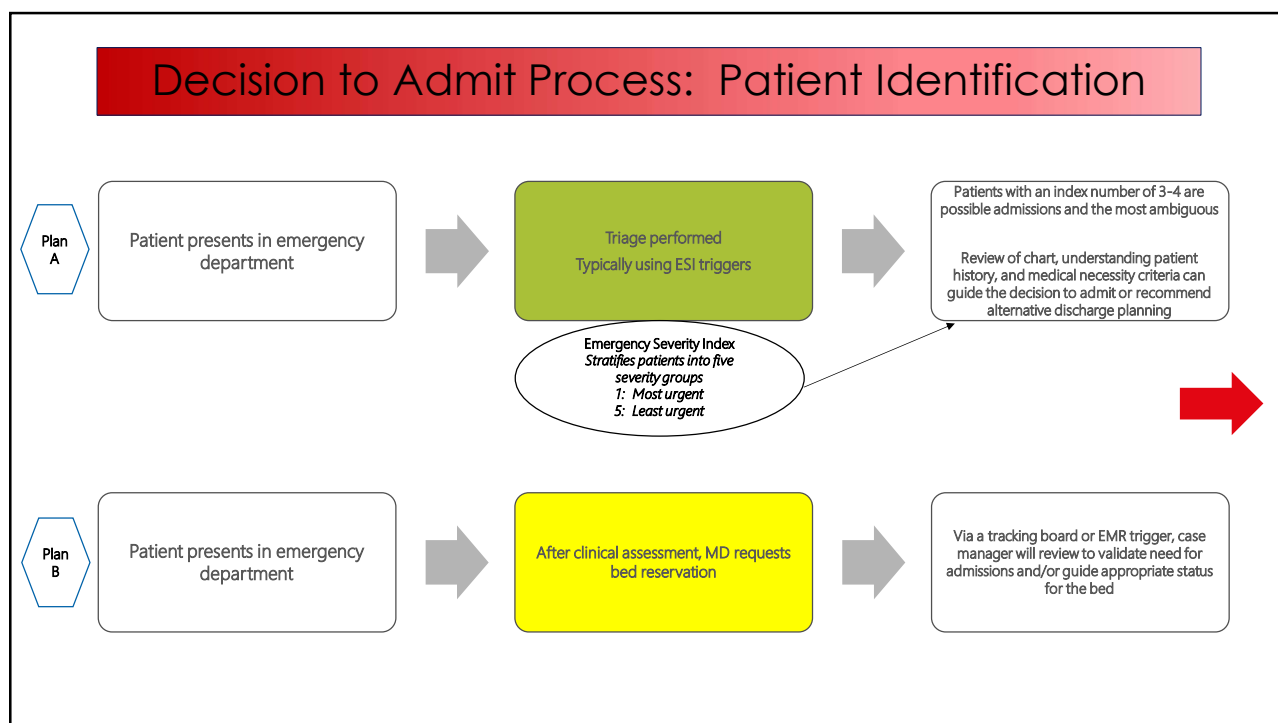
Guiding Decision to Admit



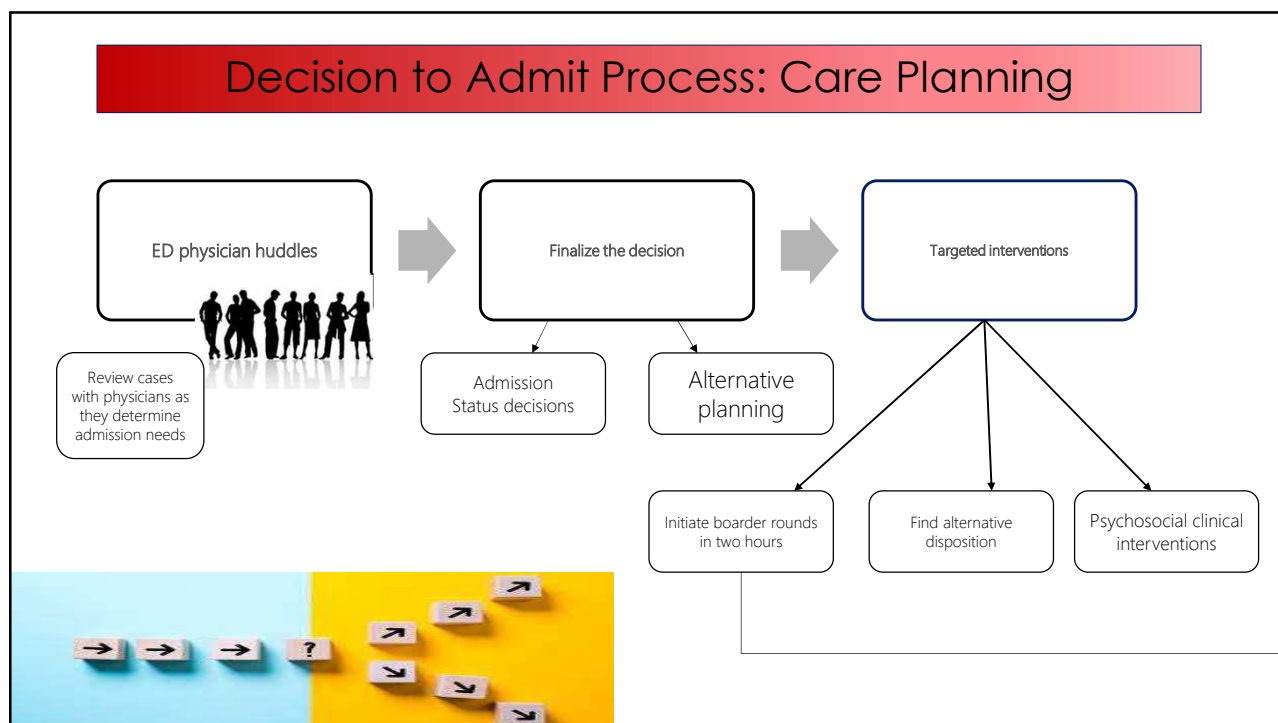
- Ensure that there is a strong framework for utilization review functions
- Use tools such as ESI codes and tracking boards to identify potential admissions
- Develop relationships with ED physicians to ensure collaboration
- Use criteria-based tools to validate necessity and status



12



13



14

Boarder Rounds

UR nurse

Care coordination RN

Social worker (ad hoc)

ED RN (ad hoc)

Evaluate current status and progress

Unchanged

Communicate with IP/CM team to prepare for admission and discharge planning needs

Status has changed

Contact admitting physician to change patient status

IP – OBS

OBS – IP

IP/OBS – OP

Dr. agrees and changes

Dr. disagrees

ESACALATE TO PHYSICIAN ADVISOR

Dr. agrees

Care Coordination/SW takes over for alternative discharge planning

Dr. disagrees

ESCALATE TO PHYSICIAN ADVISOR

Patient can be safely discharged

15

Discharge & Alternative Planning

Progress in the ED

Patient Identification

Care Planning

Sustainable Transitions

16

© 2022 HCPro, a division of Simplify Compliance LLC. All rights reserved.



Patient Identification

ESI Triggers from triage

Physician huddles

Interdisciplinary referrals

Boarder rounds

17



Care Planning

- Case management & social work assessments in the ED
- Encouraging evaluations/making referrals
- Addressing mental health needs

18



Sustainable Transitions

- Accessing community resources
- Patient & family agreement
- Mitigating high utilization

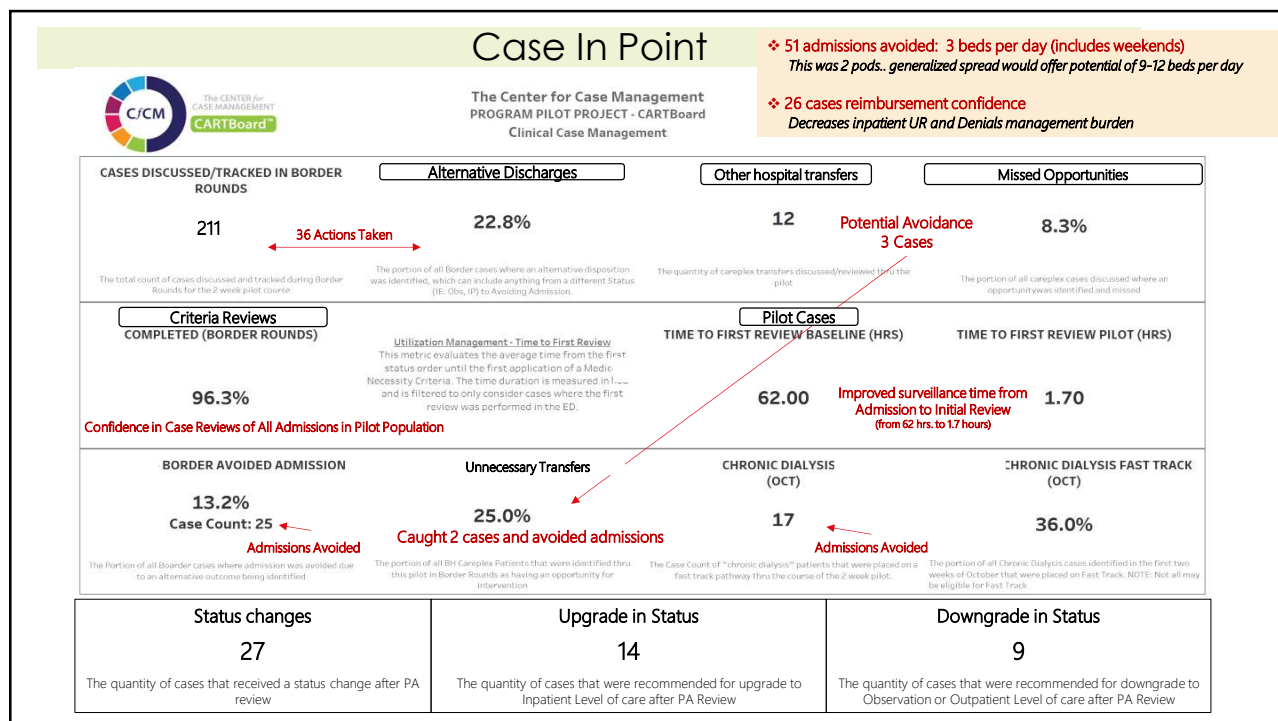
19



COVID Considerations

- Shines the light on inefficiencies
- Psychosocial/emotional implications
- Limited options for transfers due to capacity and long-term facility concerns
- Staffing shortages
- Using ED for COVID-19 diagnosis and treatment

20



21

Mastering Utilization Review and Patient Status

a NAHRI virtual event

Common ED Flow Challenges

- Lack of proactive practices—even with 20% patient boarding—overseeing if borders have changes in their status/symptoms and signal a safe discharge.
- High utilization of overall resources
- Mental Health patients seeking medical necessity clearance for beds
- Social Admissions and High Utilizer patients using the ED as their PCP's, or for Secondary Gains
- Bidirectional effect on inpatient capacity

ED Case Management Effective Practice

Utilization Management

- Guide or be a Partner in Decision to Admit
- Guide Status Decisions
- Medical Necessity Surveillance of Border Patients
- Identify Opportunities for Alternatives to Admissions

Clinical Care Coordination

- Alternative Disposition Planning
- High Utilizer Interventions

Psychosocial Support

- Addressing Social Determinants of Health to Avoid Social Admissions
- Psychosocial Interventions
- Mental Health Interventions

Anticipated Outcomes Best Practice ED Case Management

- Lower Conversion Rates (Code 44)
- Lower ED Boarder Volumes
- Decreased Readmissions Rates
- Improvements in ED Flow and Capacity
- Patient Satisfaction

Action Steps

Guide


- Guide the Decision to Admit, ensuring the right status
- Initiate Boarder Rounds

Identify & Facilitate

- Identify and facilitate opportunities for alternative discharges to avoid unnecessary hospitalization

Develop

- Develop sustainable discharge plans to reduce high utilizer population



22

Mastering Utilization Review and Patient Status

a NAHRI virtual event



Thank you!

bgeld@cfcf.com

hrohloff@cfcf.com

In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section of the program guide.





The CENTER for CASE MANAGEMENT

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

Bonnie Geld, President
The Center for Case Management

Appropriateness of hospitalization and the utilization of inpatient and/or observation care is under the microscope 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. Along with this comes the 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.

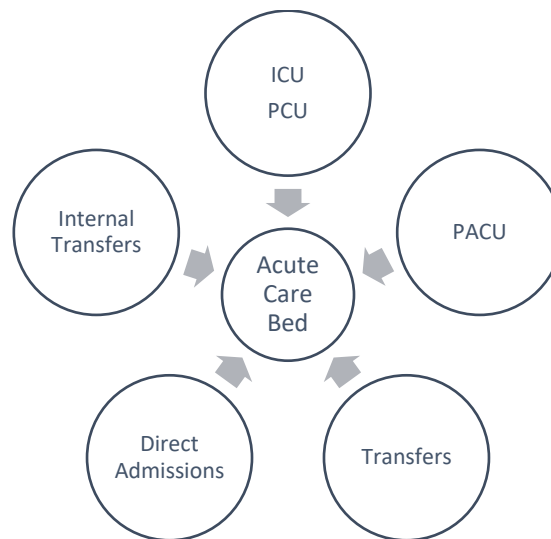
Access to care inside the hospital is reflected in 3 types of status and 4 entry points (5 including internal transfers). A patient can be identified as an inpatient, an observation patient, or an outpatient (in a bed). Case Management, with the aid of evidence-based tools and criteria, is widely recognized as the authority in guiding physicians in 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 patient's level of needs	Patients referred from an outpatient site such as Primary Care Clinics, Specialty Practices, and other outpatient centers	<ul style="list-style-type: none">• Acute to ICU• ICU to Acute• ICU to Step Down• Wrong Acute Bed

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 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 is maintained. At the end of this article, you will find a sample escalation policy.

Emergency Department

Today, the process surrounding the 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 Manager 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"> ❖ Medical Necessity Surveillance ❖ Evaluation of Status and Level of Care 	<ul style="list-style-type: none"> ✓ Participates in the decision to admit process ✓ Guide's status and level of care decisions ✓ Regularly Evaluate boarders ✓ If indicated works with payers to authorize care ✓ Present ABN's if indicated 	Cases should be escalated to a second level reviewer when the admitting physician disagrees 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"> ❖ Screens all patients for discharge planning needs 	<ul style="list-style-type: none"> ✓ Develops care plans for frequent flier patients ✓ Advocates for discharge planning needs ✓ Works and refers to social work for psychosocial issues 	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"> ❖ Follow UP Phone Calls ❖ Manages Frequent Flier Care Plans 	<ul style="list-style-type: none"> ✓ Contacting high risk patients post d/c from ED 	

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

Kathleen Walsh, RN, PHD & Karen Zander RN, MS, CMAC

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 hospital's 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 (i.e., 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 can 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 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.