Contemporary Hospital Case Management

Prepared for
CMSA Arizona 13th Annual Conference

And brought to you by
Phoenix: The Hospital Case Management Company

Sept 6, 2013
Tempe, AZ
Phoenix: who we are

- Recognized leader in the field of Hospital Management since 1994
- Range of clients from large teaching facilities to small rural community hospitals across the country
- Variety of engagements from enterprise-wide transformation to one-day on-site workshops.
- We wrote the book, the only book, on hospital case management
Our clients

* Mount Sinai
  The Mount Sinai Hospital

SHARP
  San Diego's Health Care Leader

Bridgeport Hospital
  Yale New Haven Health

Columbus Regional Healthcare System
  Well within reach.

Christus St. Patrick Hospital

Western Connecticut Health Network
  Danbury Hospital - New Milford Hospital

Ascension Health

Berkshire Health Systems

Fisher / Titus Medical Center
  Simply Smarter Care

Shore Memorial Health System

Saint Thomas Health Services

Temple University

Promedica Health System

Southcoast Health System

Mon General

Cabell Huntington Hospital

John C. Lincoln Health Network

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What is hospital case management?
*What is hospital case management?*

**ACMA:** Collaborative practice...to facilitate care along a continuum through effective resource coordination.

**CMSA:** Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes.

**URAC:** A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet a client’s health needs through communication and available resources to promote quality cost-effective outcomes.
In very practical terms, it’s a patient-centered way to work with physicians and the clinical team to make sure the patient gets the right treatment, in the right place at the right time.
Hospital case management programs were created to respond to a dramatic change in the marketplace. They continue to be market-driven and evolve based on anticipation of environmental shifts.

To better understand how case management programs are evolving to adapt to a new marketplace, let’s take a quick look at the current state of the healthcare market.

* Economic marketplace
* Regulatory marketplace
* Care management marketplace
In 2010, the U.S. spent $2.6 trillion on health care, an average of $8,402 per person.
That amount decreased in 2011 to about $2.5 trillion or 17.5% of GDP or $8,140.
The share of economic activity (gross domestic product, or GDP) devoted to health care has increased from 7.2% in 1970 to 17.9% in 2009 and 2010.
Health care costs per capita have grown an average 2.4 percentage points faster than the GDP since 1970.
Since 2002, the rate of increase in national health care spending has fallen from 9.5% to 3.9%.
Half of health care spending is used to treat just 5% of the population.
Economic marketplace

- Although only 10% of total health expenditures, spending on prescription drugs has received considerable attention because of its rapid growth (114% from 2000 to 2010).
- In 2008, 27% of the nonelderly with 3+ chronic conditions spent more than 10% of their income on health, compared to 11% of the total nonelderly population.
- Many policy experts believe new technologies and the spread of existing ones account for a large portion of medical spending and its growth.

Kaiser Family Foundation
Healthcare Spending FY 2012

- Hospital: 32.6%
- Physicians: 21.7%
- Professionals: 7.3%
- HHC: 2.9%
- Rx: 10.7%
- DME: 3.4%
- SNF: 5.9%
- Other: 15.9%
Average cost per stay by payer 2010

Costs by Payer

<table>
<thead>
<tr>
<th>Payer</th>
<th>Average Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>$10,300</td>
</tr>
<tr>
<td>Uninsured</td>
<td>$8,100</td>
</tr>
<tr>
<td>Commercial</td>
<td>$9,100</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$7,500</td>
</tr>
<tr>
<td>Medicare</td>
<td>$11,600</td>
</tr>
</tbody>
</table>

SOURCE: Agency for Healthcare Research and Quality, Center for Delivery, Organization, and markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2010
## Reimbursement Shift

<table>
<thead>
<tr>
<th>Reimbursement Method</th>
<th>Who Holds the Risk?</th>
<th>Inpatient Admission</th>
<th>Length of Stay</th>
<th>Resource Use</th>
<th>Payment Implication</th>
<th>Case Mgmt Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for Service &amp; Discounted FFS</td>
<td>Payer</td>
<td>Desirable, if LOC qualified</td>
<td>Desirable, if LOC qualified</td>
<td>Desirable, if LOC qualified</td>
<td>Payer review if outlier outcome</td>
<td>Assertive Resource Mgmt</td>
</tr>
<tr>
<td>Per Diem</td>
<td>Payer &amp; Provider</td>
<td>Desirable, if LOC qualified</td>
<td>Desirable if LOC qualified</td>
<td>Undesirable</td>
<td>Case Review if outlier outcome</td>
<td>Accurate LOC status; continuing stay monitoring</td>
</tr>
<tr>
<td>Fixed Rate (DRG)</td>
<td>Provider</td>
<td>Desirable, if LOC qualified</td>
<td>Undesirable</td>
<td>Undesirable</td>
<td>UB04 edits w/ possible refund to RAC or MAC</td>
<td>Accurate LOC status; continuing stay monitoring</td>
</tr>
<tr>
<td>Bundled Payments/ Capitation (ACO/Medical Homes)</td>
<td>Provider</td>
<td>Undesirable</td>
<td>Undesirable</td>
<td>Undesirable</td>
<td>No additional revenue beyond PM/PM</td>
<td>Accurate LOC status; continuing stay monitoring</td>
</tr>
</tbody>
</table>
2. Regulatory Marketplace

- Supreme Court
- Federal Circuit Courts
- Congress
- Centers for Medicare & Medicaid Services
  - Regional Offices
  - Intermediaries
  - Carriers
  - Peer Review Organizations
- Departmental Appeals
- Office of the Inspector General
- Medicare Integrity Program Contractors
  - Environmental Protection Agency
  - Drug Enforcement Agency
  - Federal Trade Commission
  - Federal Bureau of Investigation
  - Health and Human Services
  - Department of Labor
  - Department of Transportation
  - Department of Justice
  - Federal Aviation Administration
  - Food & Drug Administration
  - Treasury
  - Internal Revenue Service
  - Occupational Safety and Health Administration
  - Health Resource and Service Administration
  - Joint Commission on Accreditation of Healthcare Organizations
- HOSPITALS

Legend:
- State
- Federal
* Multiple Layers of Oversight
  * RAC - Recovery Audit Contractors
  * MAC - Medicare Administrative Contractors
  * MIC - Medicaid Integrity Contractors
  * ZPIC - Zone Program Integrity Contractors
  * MFCU - Medicare Fraud Control Unit
  * PSC - Program Safeguard Contractors
  * CERT - Comprehensive Error Rate Testing
  * PERM - Payment Error Rate Measurement
  * QIO - Quality Improvement Organization
  * OIG - Office of Inspector General
The Triple Aim: Care, Health, And Cost

Improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care.
<table>
<thead>
<tr>
<th>Fragmentation</th>
<th>Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider centered care</td>
<td>Patient centered care</td>
</tr>
<tr>
<td>Multiple separate providers</td>
<td>Accountable business units/medical homes/ACOs</td>
</tr>
<tr>
<td>Reimbursement rewards volume</td>
<td>Reimbursement rewards value</td>
</tr>
<tr>
<td>Lack of comparison data</td>
<td>Practice price and quality transparency</td>
</tr>
<tr>
<td>Limited accountability</td>
<td>Objective performance measures</td>
</tr>
<tr>
<td>Unequal provider payment systems</td>
<td>Physician engagement</td>
</tr>
<tr>
<td>Institutional bias - production unit silos</td>
<td>Coordination of care across the entire continuum</td>
</tr>
<tr>
<td>Denial management</td>
<td>Denial prevention</td>
</tr>
</tbody>
</table>

Adapted from M. Bella: Innovative Programs for Dual Eligibles, NASMD Nov 2009.
Average patient is asked the same question 12 times by hospital providers.

Analysis of 225,000 hospital deaths in one year:
- 12,000 -- unnecessary surgery;
- 7,000 -- medication errors;
- 80,000 infections;
- 106,000 non-error, negative effects of drugs;
- 20,000 other hospital errors.

Source: JAMA 2000;284:483-485


Research strongly suggests that coordination failures lead to medical errors, higher costs, unnecessary pain for patients and their families, and poor HCAHPS scores.

In a 2003 IOM report, care coordination is one of 20 priorities for national action to transform the health care system (Institute of Medicine, Priority Areas for National Action: Transforming Health Care Quality, Washington: National Academies Press, 2003)

NQF designation of care coordination as one of six “National Priorities” for national action
**Care Management Marketplace**

*WHO IS THE CONNECTOR?*

**Hospital Team**
- Patient
- Physician
- Pharmacist
- Nurse
- Social Services
- Case Manager
- Allied Health
  - Respiratory Therapist
  - Dietitian
  - Physical Therapist
  - Educator

**Community Team**
- PCP
- Specialist
- Skilled Nursing Facility
- LTC Services
- Pharmacy
- Community Clinic
- Home Care
- Rehabilitation
- Hospice
- Community Resources
- Health Plan
- Medical Home

Who is the Connector?
### Year by Year Care Management Risk

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Value Based Purchasing</strong></td>
<td></td>
<td>1%</td>
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<tr>
<td><strong>30 day readmissions</strong></td>
<td>1%</td>
<td>2%</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Acquired Conditions</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total at Risk</strong></td>
<td>2%</td>
<td>3%</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6%</td>
</tr>
</tbody>
</table>
These rapidly escalating marketplace demands set the stage for the next phase of hospital case management evolution.

The team that bridges the clinical and business world and the glue to hold much of these expectations together will be case management.
* **Market force:** The implementation of the Prospective Payment System (PPS) in 1983

* Hospital case management was introduced in New England Medical Center as a Clinical Nursing Delivery System designed in response to the PPS.

* Based on the principle that the nurse at bedside is best positioned to work with physician to effectively manage progression-of-care, query questionable medical interventions, reduce excessive costs, and plan for timely discharge.

* A “Nurse Case Manager” was the single, consistent resource to the patient, the physician and the clinical team.
HCM v1.0 - Clinical case management models

Results:

* Successful at influencing physician practice decisions at the bedside.
* LOS decreased or stayed at or near the trim point

But.....Economists had theorized that with the intro of PPS, ‘production’ processes would gain efficiencies; and that the ‘volume’ of care would be reduced.

- Medicare length of stay plummeted but costs of care remained static.
- Within 3 years, the financial effect of PPS had serious consequences on economic survival.
* **Market Force:** The revenue free-fall after the introduction of the PPS resulted in closure of roughly 1500 hospitals across the nation. Hospitals which intended to survive underwent ‘re-engineering projects’ to reduce indirect costs and FTEs.

* Hospitals combined utilization review (UR) and social work (SW) departments and created HCM departments to conduct their respective functions.

* Action moved from the nurse at the bedside to people reviewing charts
HCM v2.0 - Functional Models

Results:

Role function dedicated to task completion - UR and discharge planning activities.
No formal training in case management - role confusion.
Disappearance of Social workers.
Professional tension between disciplines.
“Chart police” >>>>>> Physician resistance
LOS decreased - but costs remained high.
HCM V.2.1

* Consolidated Model
  * The functions of SW and UR continued under a case management umbrella
  * UR Nurses > chart review for UR
  * SW > discharge planning
  * Additional chart review tasks - Core measures

HCM v. 2.2

* Integrated Model
  * The functions of discharge planning and UR were integrated into a single position
  * UR Nurses > chart review and discharge planning
  * Additional chart review tasks - CDI; core measures; POA; et al. Many also did CDI
Market Force: The publication of the IOM’s ‘To Err is Human’ in 1999 became the rallying cry for safety, quality and value.

Market Force: The MMA of 2003 sent out warning signals to prescient hospital execs when the Feds authorized the creation of the RACs and the MACs. Section 501(b) of the MMA authorized public reporting.

Market Force: The DRA of 2005 authorized the conversion from P4R to P4P - Value Based Purchasing

- Estimated $6.67 million at risk per hospital over first 5 years
This decade’s marketplace signals the introduction of *Third Generation outcome models (HCM v.3.0)* of hospital case management and reflects a return to the original progression-of-care intent:

* Point of care planning and decision making
* Facilitate patient’s journey through healthcare system
* Improve delivery of care processes
* Orchestrate team support for safety and quality
* Promote swift and safe transition
* Influence responsible use of resources
* Encourage use of evidence based protocols
* Reduce risk, fragmentation and inefficiencies
* Advocate for stakeholders
Hospital case management has always been a market driven strategy.

Models that worked in past markets, just will not work now. Old models can no longer stand up to new and escalating demands. Disruption in the entire healthcare environment is upon us and no where is it felt more keenly than the hospital environment.
HCM v.3.0 - Third generation outcome models are characterized by:

1. Pro-active advocacy
2. Progression-of-care
3. Value added practice
4. Interdisciplinary coordination
5. Objective scorecards
1. **Pro-Active Patient Advocacy**
   - Speaking for, fighting for, and standing up for patients.
   - Reduce clinical and financial risk and promote quality and safety.
   - Acting as a liaison in the healthcare system.
   - Bridging communication gaps between patient and other professions and the healthcare system.
   - Educating and informing the patient.
   - Enhancing the patient experience.
Pro-Active Patient Advocacy

* **Practical Application**
  * Divert from high-risk hospital venue if needs can be met at lower and safer level of care
  * Treatment plan focused on reason for admission and within patient/family preferences.
  * Minimize non-contributory and excessive medical interventions.
  * Influence evidence based medical interventions.
  * Orchestrate care team expertise.
  * Communicate, educate, inform.
  * “Do no harm”
2. Progression-of-care

* Pro-actively “address the challenges posed by the complexities of today’s hospital operations, fragmentation of service, and paucity of interlocking accountabilities.”

HFM August 11, 2011

* The new breed of hospital case managers facilitate the patients’ navigation through the entire acute care episode to achieve desired results efficiently, safely and cost effectively.
## Case Management Progression of Care Continuum

<table>
<thead>
<tr>
<th>ACCESS</th>
<th>CARE MANAGEMENT</th>
<th>TRANSITION</th>
<th>COMMUNITY CONTINUUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gate-keeping:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• “First time Quality”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Standard access mgmt process</td>
<td></td>
<td></td>
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<tr>
<td>• Co-location of CDI/UR</td>
<td></td>
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<tr>
<td>• Medical necessity</td>
<td></td>
<td></td>
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<tr>
<td>• Bed mgmt with regionalization</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Admission &amp; discharge criteria for specialty units</td>
<td></td>
<td></td>
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<tr>
<td>• Tightly managed observation patients (CDU)</td>
<td></td>
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<tr>
<td>Patient navigation:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Care coordination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Accountable care units</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• EBM protocols</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Critical care/Telemetry criteria</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Safety and quality compliance</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Quantify touch-point obstacles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical practice behaviors</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Documentation coaching</td>
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<td></td>
<td></td>
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<tr>
<td>Transition:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Expectation mgmt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Early and ongoing post acute need evaluation</td>
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<td></td>
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<tr>
<td>• Resource center support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patient and family readiness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Coordinated transitions of care</td>
<td></td>
<td></td>
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<tr>
<td>• Seamless transitions</td>
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<tr>
<td>“Going the Distance”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Population health</td>
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<td></td>
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<tr>
<td>• Extensionists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Transitionalists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Community clinics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pharmacy outreach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical homes</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Primary care</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Telemedicine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Preventive care</td>
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</tbody>
</table>
Progression-of-care

- Radical shift in case manager orientation.
- It requires a shift in workflow activities, priorities, and problem solving.
- It demands high level critical thinking, communication & negotiation skills.
- It challenges the assumption that discharge planning is a distinct process rather than the end result of a successfully managed progression-of-care.
- Anticipate obstacles that may delay progression-of-care.
- Focus on care coordination.
- Move from completing tasks to influencing activities that impact progression-of-care.

- Physician practice behaviors
- Delivery of care obstacles
“In the healthcare industry, a ballpoint pen can be more dangerous than a scalpel”

Richard Dick, PhD, CEO, Ascent Technology, Alpine, Utah

“The biggest cost drivers of healthcare are when physicians are putting pen to paper to write orders”

www.cerner.com
“The avoidable day is the most expensive item commonly provided by a hospital.”

Elgin Kennedy, MD
Mage Corp.
CORRELATION BETWEEN PROGRESSION OF CARE DELAYS/AVOIDABLE DAYS AND PAYER DENIALS

POCD/PAD and Denied Days

Payer Denied Reimbursement

Avoidable  Denied

Month
3. Value - Added Practice

Hospital case management is no longer about UR and DCP; HCMs are now expected to align their practice activities with medical staff practice, influence clinical costs associated with practice variations, overcome obstacles to progression-of-care, promote coordination of care among various caregivers, assimilate more info about economic factors, pro-actively advocate on behalf of the patient, facilitate seamless hand-offs to community resources and understand the impact of political trends on funding and resource availability.
Value - Added Practice

- Workflow activities that increase value.
- New population health initiatives.
- Reacting to old problems in entirely new ways.
- Patient-centered behaviors to enhance the patient experience.
- Case management practice distinguished from utilization review function
*Best Practice Features*

Value - Added Practice

Utilization review - Chart review for admission appropriateness [medical necessity] and continuing stay...retrospective

Resource management - *Prospective and Concurrent* monitoring of processes and interventions to ensure appropriateness to the patient’s immediate needs and necessity to the desired outcome. *To prevent an unwanted event from occurring in the first place!*
DRG 79 - RADIOLOGY SERVICE UTILIZATION

Best practice = Predicted cost for Severity Group 2 based on Endorsed Medical Protocol

Severity adjusted costs

Mean  Best Practice  Dr. 1332  Dr. 1554  Dr. 1336  Dr. 2117

A  M  J  JU  A  S  O  N  D
4. Interdisciplinary Coordination

- Integrating individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the patients and families throughout continuum.
- One stop effort as opposed to many separate evaluations, interpretations and plans.
- Cross-disciplinary interactions and team consistency.
- Understand fundamental constraints and imagine new possibilities.
Interdisciplinary Coordination

Practical Application

• Single patient-centered plan of care
• Structured communication process
  • Hand-off
  • Huddles (table rounds, flash rounds, etc)
  • Weekly ground rounds
• Plan for the stay; plan for the day; plan for the way; plan for the pay
• Progression of care barriers and strategies to remediate or escalate
• Transfer of knowledge and strategies to group
5. **Measurable outcomes**

- If you can’t measure it, you can’t manage it!
- It’s a way to back up and document assumptions and perceptions.
- Data must be actionable! “Actionable” means that the data inform a decision or action leading to change.
- For data to be actionable, they need to be presented in a form that provides the insight a user must have to take action.
- A program scorecard is written evidence of performance results.
# Outcome Measures

## Turning Data into Information

### Progression of Care Data

<table>
<thead>
<tr>
<th></th>
<th>Aug Days</th>
<th>Sept Days</th>
<th>Oct Days</th>
<th>Nov Days</th>
<th>Dec Days</th>
</tr>
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<tbody>
<tr>
<td>Consult not related</td>
<td>16</td>
<td>11</td>
<td>9</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Pre-op days</td>
<td>8</td>
<td>9</td>
<td>9</td>
<td>6</td>
<td>2</td>
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<tr>
<td>Test as outpt</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Inpt not obs</td>
<td>18</td>
<td>17</td>
<td>16</td>
<td>7</td>
<td>8</td>
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<tr>
<td>Inpt rad only in PM</td>
<td>14</td>
<td>16</td>
<td>11</td>
<td>6</td>
<td>7</td>
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<tr>
<td>On call won’t d/c</td>
<td>23</td>
<td>20</td>
<td>18</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>CC bed not avail</td>
<td>22</td>
<td>19</td>
<td>17</td>
<td>11</td>
<td>9</td>
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<tr>
<td>Rx not transcribed</td>
<td>16</td>
<td>15</td>
<td>11</td>
<td>8</td>
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<tr>
<td>Refuse to lower LOC</td>
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<td>rehab bed n/a</td>
<td>18</td>
<td>17</td>
<td>12</td>
<td>11</td>
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<td>social admission</td>
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<td>5</td>
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<tr>
<td>Pt/fam indecision</td>
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<td>15</td>
<td>13</td>
<td>10</td>
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<td>Delay in consult</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>213</strong></td>
<td><strong>202</strong></td>
<td><strong>169</strong></td>
<td><strong>122</strong></td>
<td><strong>96</strong></td>
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</tbody>
</table>
# Outcome Measures

**Turning Data into Information**

**Progression of Care Information**

<table>
<thead>
<tr>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>YTD REV</th>
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<tbody>
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<td>Days</td>
<td>Dollars</td>
<td>Days</td>
<td>Dollars</td>
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<td>15128</td>
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**TOTAL $**

<table>
<thead>
<tr>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>YTD REV</th>
</tr>
</thead>
<tbody>
<tr>
<td>805,566</td>
<td>763,964</td>
<td>639,158</td>
<td>461,404</td>
<td>363,072</td>
<td>3,033,164</td>
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</tbody>
</table>

**POTENTIALLY LOST**

*Fixed rate accounts for 78% of payment*

*Based on average revenue ppd*
# Outcome Measures

## Turning Data into Information

### Progression of Care Information

**TOP 10 OBSTACLES TO TIMELY PROGRESSION-OF-CARE AND DISCHARGE 2008**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Source</th>
<th>PADs</th>
<th>Unreimb costs</th>
<th>Avoided via CM Intervention</th>
<th>Recovered/Saved</th>
<th>Net Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>June N1,N2,N3</td>
<td>Rx not transcribed</td>
<td>Nursing</td>
<td>67</td>
<td>282,941</td>
<td>22</td>
<td>92,906</td>
<td>190,035</td>
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<td>W/E Surgery</td>
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<td>41</td>
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<tr>
<td>June S5</td>
<td>Step down bed</td>
<td>System</td>
<td>32</td>
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<td>29,561</td>
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<td>June S12</td>
<td>No Med Nec</td>
<td>Med Staff</td>
<td>31</td>
<td>130,913</td>
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<td>71,791</td>
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<td>June D11</td>
<td>Pre op day</td>
<td>Med Staff</td>
<td>24</td>
<td>101,352</td>
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<td>92,906</td>
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<tr>
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<td>SW not avail</td>
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<td>17</td>
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<td>On call MD won't DC</td>
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<td>Incorrect LOC</td>
<td>Med Staff</td>
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<td>33,784</td>
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**June**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Source</th>
<th>PADs</th>
<th>Unreimb costs</th>
<th>Avoided via CM Intervention</th>
<th>Recovered/Saved</th>
<th>Net Outcome</th>
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</thead>
</table>

**July**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Source</th>
<th>PADs</th>
<th>Unreimb costs</th>
<th>Avoided via CM Intervention</th>
<th>Recovered/Saved</th>
<th>Net Outcome</th>
</tr>
</thead>
</table>

**YTD**

- **489,868**
- **1,541,395**

St. John/S. Silva

Based on Av Daily Costs w/o OB/Nurs

© 2013 Phoenix Medical Mgmt, Inc.
Hospital case management is often an ‘invisible’ program. At its best, the traditional DCP activities and medical necessity screenings are going well and the C-suite is content.

At its worst, it is understaffed, undertrained, and overworked with a significant amount of role confusion and inconsistent physician cooperation.

If you do not upgrade services and create a case management experience that colleagues embrace and which anticipates changing environmental demands, the program will diminish in its capacity to effect results.

*Good luck from*

*Stefani Daniels, RN, MSNA, CMAC, ACM, President and Managing Partner*

*Phoenix: The Hospital Case Management Company*

*Pompano Beach, FL 877.941.6505*

[www.phoenixmed.net](http://www.phoenixmed.net)  
[daniels@phoenixmed.net](mailto:daniels@phoenixmed.net)