Making hospital care management an organizational priority: Dartmouth-Hitchcock deploys case managers so patients are at the right place at the right time

Case managers are consummate team players, working with everyone from patients to their support systems, from physicians to nurses, social workers and pharmacists, from coders to administrators, all on the behalf of patients, to ensure patient-centered care. Taking on this role in the hospital setting can be challenging, but Dartmouth-Hitchcock Medical Center (DHMC), based in Lebanon, N.H., shows that it can be done—and how it can be done successfully.

As director of DHMC’s Office of Care Management, Amy M. Smith, RN, MSN, CCM, oversees care management and coordination, case management, social work, discharge planning, utilization management, lifeline services, community resources and language and interpreter services. A large part of her responsibility is to ensure patients are receiving the appropriate level of care, by the appropriate level professional.
What’s happening at DHMC illustrates the tremendous changes underway—changes that have a direct impact on the professional case manager. Health care reform introduced challenges for case managers; more than ever before, they need to enhance efficiency and effectiveness of care delivery in measurable ways. Although case managers have always served as connectors, today’s focus on accountable care delivery and care transitions has expanded this role. Three aspects have particular significance for professional case managers in the hospital setting, says Patrice Sminkley, CEO of the Commission for Case Manager Certification.

- New team-based collaborative models challenge the status quo and, she says, could create new opportunities and greater need for defined roles and job requirements for the professional case manager. Understanding how to optimize the inter-disciplinary health care team is critical in yielding positive patient outcomes.

- Second, a stronger emphasis on data, measures and quality improvement underscores the need for case managers to be lifelong learners—or get left behind. “There are new people on our health care teams to whom case managers are responsible—people who understand, know and manage the metrics that enhance patient outcomes and track financial impact.”

- Third, the focus on reducing fragmentation and easing care transitions to prevent unnecessary readmissions is directly tied to a hospital’s bottom line—and the time is now to understand and demonstrate that the role of the professional case manager is essential.

One organization that recognizes the value of case management and has made it an organizational priority is Dartmouth-Hitchcock Medical Center.

**Building the team**

DHMC’s care management program is structured as a triad. RN case managers take the lead, Smith says. Completing the triad are social workers and utilization review RNs.

Other team members include continuing care managers. These RNs and social workers—many of whom are board-certified case managers—focus on high-risk outpatient populations. Resource specialists support care management staff by making referrals, handling routine paperwork and other tasks. They help fill the growing need for non-clinicians, she explains. All have a bachelor’s degree and are, she says, “amazing.” With their help, the RN and MSW case managers can work to the top of their licen-
sure. Overall, the ratio of care managers (including case managers) to patients is 1 to 20.¹

Physicians are part of the team; physician advisors, also called associate medical directors, support care management initiatives at DHMC. There are seven physicians overall: five hospitalists, one surgeon and one ED physician. Having them as part of the care management team has led to a significant decrease in unsigned orders. Team roles and responsibilities may be changing, but physicians are still more willing to listen to their peers, says Smith. In fact, having these physicians on her team was a tremendous selling point for her job, she says. A large part of their responsibility is educating fellow physicians and, when needed, following up on unsigned orders and other issues that stymie coordinated care.

Operational policies that support patient flow

DHMC initiated a policy that all admission orders must be signed within 24 hours. Smith and her team are making this happen by wisely deploying physicians, building “work cues” into the EHRs and creating workflows.

This cuts down the number of unsigned orders considerably.

¹ The DHMC care management program encompasses case management, and it includes many professional and board-certified case managers. Because it expands beyond case management proper, it also include utilization review and other care management functions that don’t constitute true case management.

“Doctors are finally being held accountable to signing their orders” she says. She credits her physician advisors and senior leadership for their support: The chief medical officers stand behind the care management efforts, and the advisory committee provides peer support—and pressure. “There will always be some physician resistance. That will never go away.

Care management at every point of entry

The goal, she explains, is to have a care management process at as many points of entry as possible. She describes three key opportunities for care management at the “front door”:

In the emergency department: RN case managers staff the emergency department and give evidence-based recommendations about which patients to admit, which to discharge and which require observation services. Forty percent of admissions come through the ED at Dartmouth-Hitchcock. Since last fall, emergency department physicians have had admitting privileges, which increases efficiency and reduces the number of unsigned orders. To improve care for patients receiving observation services, DHMC opened a five-bed clinical-decision unit directly off the emergency department. One advantage of that change: It avoids the confusion that ensues when a patient under observation is housed on an in-patient unit.

At the transfer center: The transfer center is available 24/7 to help facilitate urgent/emergent transfers to DHMC. Twenty percent of admissions come through the transfer center. Calls are answered by an experienced registered nurse representative. DHMC generally runs at capacity, so this level of triage is critical. Transfer volume

“Like all of us in health care, licensed or non-licensed, all physicians really want is to take care of their patients.”

— AMY SMITH, RN, MSN, CCM, DIRECTOR OF CARE MANAGEMENT, DARTMOUTH-HITCHCOCK MEDICAL CENTER
The goal is to ensure the patient is placed in the right level of care upon transfer.

In the OR: Dartmouth-Hitchcock performs approximately 20,000 surgeries a year. Each morning, utilization review RNs go over the operating room bookings to ensure each patient has an appropriate order. For instance, they review all surgeries booked with an inpatient-only CPT code to ensure the admission order is placed pre-op. They also review patient charts after surgery to identify any patients who may meet inpatient criteria. If the patient has an inpatient-only surgery without an inpatient order, it will be treated as an outpatient surgery (from a billing perspective). It is crucial to have the inpatient order in and signed prior to surgery. If the order is not placed pre-op, and the patient has a three-day stay with an inpatient order post-op, CMS will bundle the surgery into the inpatient claim.

This “front door” approach has led to more efficient and appropriate transfers, better compliance with Medicare regulations (which means fewer penalties), better communication across and within teams, and a more efficient and less stressful admissions process, regardless of the point of entry.

Hubs and cogs and spokes

The professional case managers in these examples work with clinicians, other staff and patients to make sure the patient is at the right place at the right time, all the time,” Smith explains. They work with the physician advisors to make sure patient status is correct “right from the front door.” They are charged with improving throughput and transitioning the patient to the next level of care with seamless communication and transition planning. Everyone has clear job descriptions.

In addition to managing transitions, physician advisors and case managers work with the revenue cycle team on compliance committees to identify areas of vulnerability for compliance and lost revenue.

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— AMY SMITH, RN, MSN, CCM, DIRECTOR OF CARE MANAGEMENT, DARTMOUTH-HITCHCOCK MEDICAL CENTER

Two of the four DHMC affiliate hospitals now have a supervisor of care management who reports to Smith. It’s a balance. “We are working towards standardization of our care management processes, but with local autonomy. What works here at a bigger hospital isn’t necessarily going to work at a smaller facility,” she says. “There is no ‘one size fits all’ for care management structures.” Much is negotiable; the approach has to fit the facility’s needs and culture. What’s not negotiable, she says, are strong, aligned and seamless care transitions; they are necessary now and will continue to be in the future.

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has increased 65 percent in the past year and DHMC had to turn away 1,100 acute transfers in 2015. Physicians play an important role here. “Dartmouth-Hitchcock has a unique quarterback model to ensure appropriate admissions are coming in through the transfer center,” Smith says. A physician—usually one of her physician advisors—covers the transfer center and helps determine the status of patients being transferred from other hospitals or directly from physician offices. Among the considerations:

- Do they meet acute care criteria?
- Do they need tertiary care? If so, what type?
- Can the patient be supported at the referring hospital?
- Do they meet other criteria—ACO, acuity, etc.?
Care management efforts extend to the primary care setting, with 40 care coordinators, many of whom are RN or MSW case managers. Dartmouth-Hitchcock is also moving to a more formalized transitional care program.

“The goals of integrated care management should be improving outcomes and quality and decreasing utilization and costs; and the patient should be at the center of everything we do,” Smith says. By that measure, the program has succeeded.

Systematizing care management has increased efficiency and reduced unnecessary costs. It has improved communication and patient transitions, increased the number of signed orders—and the speed with which they are signed—and led to an increase in appropriate transfers.

She offered advice for hospital-based case managers who would like to implement elements of her approach.

- Challenge the norms. “Ask ‘What if we did this?’ instead of saying ‘We can’t do this.’”

- Cultivate a strong network of peers and share best practices within and across organizations.

- Keep up. Part of that involves continuing education, she says. “We have to be well educated and well informed.” It also involves staying current on regulatory changes. The case manager not only needs to understand what to do and how to do it, but why—and that generally relates to Medicare rules and reimbursement issues.

- Get it in writing. “Documentation is always your strongest defense to receive payment. Ask the physicians to ‘think in ink.’”

- Strong physician-advisor program is, from her perspective, indispensable—especially when it comes to achieving compliant levels of care determinations.

- Strong collaborative relationships with revenue cycle partners will be essential to reduce risk. Those partners include billing, coding, patient access, patient financial services and compliance.

**Moving forward**

Changing demographics, a dynamic regulatory environment and a focus on team-based patient-centered care are driving the need for case management services; solutions require imagination, innovation and hard work. “As we shift from volume- to value-based care we are challenged to imagine how we will identify, engage and manage the care of patients,” Smith says. “We need to find new ways to engage and align physicians and other caregivers in creating better-coordinated care across the continuum.”

Sminkey agrees, and believes board-certified case managers are up for that challenge. Case managers understand better than anyone else the complexities of the continuum and they know how to integrate all the members of the care team. If anyone can align clinicians, caregivers and support staff, it’s them. “Board-certified case managers have the credential that demonstrates more than just competence, but peer-recognized capabilities in the team-based health care environment, in the hospital and across the full health care continuum.”

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Patrice Sminkey, Chief Executive Officer, Commission for Case Manager Certification

Sminkey comes to the Commission from URAC, where she most recently served as senior director of sales. Prior to that, she was senior vice president, operations and client management, Patient Infosystems in Rochester, N.Y. She brings a proven track record in operations management in small and large operations, multilevel services and cross-functional teams. She has extensive experience in client management and coordination, including marked improvement in client retention, timely and fiscally sound program implementation and an expanding book of business.

As chief executive officer, Sminkey oversees the management of all activities related to the Commission’s operations, including all programs, products and services; and the provision of quality services to and by the Commission. She is a direct liaison to the Commission’s Executive Committee. She works with CCMC’s volunteer leadership to evaluate and develop potential new products for implementation by CCMC, and she establishes and maintains communication and working relationships with other organizations, agencies, groups, corporations and individuals.

She holds a diploma of nursing from the Chester County School of Nursing.

Amy Smith, RN, MSN, CCM Director of Care Management Dartmouth-Hitchcock Medical Center

Smith oversees care management, social work, care coordination, discharge planning, utilization management, lifeline services, community resources and language and interpreter services for Dartmouth-Hitchcock.

She discovered her passion for nursing while finishing a bachelor’s degree in psychology. After graduation, she immediately returned to nursing school. After earning her degree, she took a specialty position in NICU, PICU and pediatric emergency department nursing at SSM Cardinal Glennon Children’s Hospital in St. Louis. Smith has more than 12 years of nursing experience in acute care settings.

An interest in the business side of health care led to case management. Amy initially worked in the health plan segment. After achieving her CCM certification she completed a master’s degree in nursing, with a special focus on leadership and management. Smith has held several management positions in both the payer and provider worlds. At Dartmouth-Hitchcock, she is part of a pioneering organization during this time of frequent changes and challenges. She is an active member of the Rotary club of West Lebanon, N.H., and is on the board of the Maynard House, a hospitality house for patients’ families.

Join our community of professional case managers!