HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

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Talk to each other to improve patient care, reduce readmissions

Beef up communication inside, outside the hospital

When hospital staff start examining the reasons patients are being readmitted, the famous line from the movie *Cool Hand Luke* may come to mind: "What we've got here is failure to communicate."

Many readmissions occur because some vital piece of information falls through the cracks when patients transition between levels of care. In other scenarios, patients may come back to the hospital because they didn't understand the discharge instructions or the importance of following them, their living situation or financial issues made it difficult to follow the their treatment plans, they were unhappy with their post-acute facility, or because they couldn't afford their medication or needed post-acute services that were not covered by insurance.

In many of these cases, the readmissions could have been avoided

EXECUTIVE SUMMARY

Lack of communication prevents clinicians from delivering coordinated care, which often results in adverse effects on the patient and the hospital's bottom line.

- Healthcare providers need to move from a fragmented system to an integrated one where entities across the continuum communicate and work together to improve patient care.
- Case managers should develop strong working relationships with post-acute providers, case managers at community organizations, and their counterparts at health plans.
- Multidisciplinary rounds are essential for breaking down organizational silos and ensuring that all clinicians are on the same page.

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if the hospital clinicians had better communications with each other, with their peers at post-acute providers, with healthcare payers, and with the patients and families themselves, the experts say.

"When clinicians operate in silos with little communication, it prevents them from delivering the coordinated care needed to meet quality standards and financial aspects. It's important to build relationships with the staff inside the hospital and with post-acute providers," says **Jean Maslan**, BSN, MHA, CCM, ACM, managing consultant for Berkeley Research Group, with headquarters in Emeryville, CA.

The new systems of reimbursement, such as Value-Based Purchasing, bundled payments, and other initiatives are changing the way care is provided for patients and make it imperative for clinicians in the hospital setting to communicate and collaborate with their peers across the continuum, says **Patricia Hines**, PhD, RN, managing director for Novia Strategies, a national healthcare consulting firm.

"Insurers are rapidly following CMS and adopting their own value-based payment initiatives. Hospitals are going to have to rethink how they approach the delivery of care and what skills are needed for success," she says.

One of the big changes case managers must make is to shift their thinking from focusing solely on individual cases and what happens in each department of the hospital and start thinking about how every part of the entire continuum works on behalf of the patient, Hines adds.

Hospitals have taken the first step toward providing care across the continuum as they participate in accountable care organizations and bundled payment agreements, which mandate communication between providers, says **Brian Pisarsky**, RN, MHA, ACM, associate director at Berkeley Research Group.

"Many hospitals have started to develop relationships with local skilled nursing facilities and home health agencies, but few have built a comprehensive program that truly looks at patients along the entire continuum of care," he says.

The problem hospitals face with all of CMS' quality initiatives is that the current healthcare infrastructure was built for volume and not value, Pisarsky points out.

"We have to make a fundamental change in the day-to-day work of case managers. It's no longer just utilization review and discharge planning. It takes a different approach from what we've done in the past and it means good communication with every provider throughout the continuum who comes in contact with the patient," he says.

Hospitals need to make operational changes to ensure that patients overcome the clinical barriers to a safe discharge, Hines says. "Today's healthcare system may not allow hospitals and other providers to do well in the future without making major changes in the way they work within their systems and across the continuum of care. Our fragmented healthcare system has to move to a more integrated model in which all members of the healthcare team collaborate on behalf of the patients," she says.

Instead of limiting your communication with other team members to text messages and emails, get the entire team together every day and talk about each patient on the unit, Maslan advises.

"Multidisciplinary rounds

are so important because they involve person-to-person direct communication. The process builds a team on the unit because everybody is getting together and talking about goals and advocating for the patient. Too much is lost when we rely on technology for communication," she says. *(For tips on conducting multidisciplinary rounds, see related article on page 4.)*

Communication with patients and family members is also extremely important, not just during the initial assessment but throughout the stay, says **Peggy Rossi**, BSN, MPA, CCM, a retired hospital case management director who now is a consultant for the Center for Case Management.

Case managers need to take the time to find out about the patient's living situation, support in the community, healthcare literacy, financial issues, and other details in order to develop a workable discharge plan, she adds.

In addition, case managers need to ensure that patients and families understand the patient's condition and prognosis as well as their responsibilities after discharge.

"Patients are so sick when they are discharged that often the family doesn't understand what is happening. One reason patients are being readmitted is that they get home and don't know how to take care of themselves, or the family doesn't realize the extent of the care they have to provide. It behooves us as case managers to make sure patients and families get the information and education they need before discharge," she says.

Rossi recommends individual team and family case conferences for patients with complex needs. "The team needs to meet first to develop strategies and then schedule a meeting with the patient and family," she says.

Everyone who comes in contact with the patient should talk about the estimated date of discharge and plan of care, rather than discussing it the day the patient is scheduled to be discharged, Maslan says.

In addition to providing extensive patient and family education, hospital case managers need to have good communication with case managers at the home health agency and the health plan who can take over the care coordination, Rossi adds.

"Bundled payments and accountable care organizations make it necessary for hospitals and post-acute providers to communicate and that's a good thing for patients," Maslan says.

Focus on the big picture and develop relationships with all providers in the community who treat patients after discharge, she adds. These include case managers at physician offices, community case managers such as those at the Area Agency on Aging, skilled nursing facilities, and home health agencies, she says.

"It's important to have that connection between the inpatient case manager and the community case manager who may be going into the patient home or working with the patient at the physician office. That way, they know what is going on with the patient and can give the patients the same message they received in the hospital," Maslan says. *(For more information on building relationships with post-acute providers, see the December 2015 issue of* Hospital Case Management*.)*

Hospital case managers should communicate with their counterparts at the patient's payer organization, Rossi says. "So often the hospital and health plan don't communicate except when there is the potential for a denial. But if a high-risk patient is going home, the hospital case manager should alert the case manager at the health plan about providing post-discharge care," she says.

"Once patients leave the hospital, hospital case managers lose touch with them. But if they collaborate with the health plan case manager about post-discharge services, patients will benefit," she says.

Some hospitals have developed joint operations committees to meet quarterly with representatives from key health plans, Rossi points out. "This opens up communication and helps the hospital and health plan work collegially to improve patient care, and not just in an adversarial manner when the health plan make a denial," she adds.

Technology has made it easier to communicate but it can't replace face-to-face communication, Maslan adds. She advises case managers to spend less time in the electronic medical record and more time talking face to face with their patients and the treatment team.

"It may take case managers 20 minutes to find out about a patient by reading a chart, but they can walk into a room and know what is going on in 30 seconds," she says.

As they document, clinicians need to get in the habit of painting a clear picture of the patients, their conditions, their needs, and the plan of care so that whoever is on the treatment team can see what the issues are, Rossi says.

"When the communication is by email or texting, the whole team doesn't get to see what the issues are. It doesn't take that much time to succinctly make a note after your visit with a patient. The notes can be used as a handoff for the provider so they understand what is going on," she says. ■

Multidisciplinary rounds help remove the silos, improve communication

Team should meet every day to collaborate on patient care

Multidisciplinary rounds are the key to improving communication among all disciplines on the treatment team and facilitating collaboration on the patient's plan of care, says **Jean Maslan**, BSN, MHA, CCM, ACM, managing consultant for Berkeley Research Group, with headquarters in Emeryville, CA.

"Rounds are a time to get all of the disciplines on the same page so everyone will have the same message to patients. Having daily multidisciplinary rounds should increase quality metrics and increase patient and staff satisfaction," she says.

Multidisciplinary rounds remove the silos in which clinicians often operate because everyone is talking to each other, says **Peggy Rossi**, BSN, MPA, CCM, a retired hospital case management director who now is a consultant for the Center for Case Management.

"In today's healthcare environment, it's important for all the disciplines to act as a team and collaborate on patient care and moving patients safely through the continuum. They make the discharge process smoother because everyone is aware of the barriers to discharge and works to remove them," she adds.

Rossi suggests that hospitals develop two types of rounds: daily rounds that focus on length of stay and a safe discharge, and complex rounds for high-risk patients with multiple comorbidities and complex needs.

The daily rounds should be quick and efficient and include a one-to-two minute discussion of each patient, including what happened in the last 24 hours, why they still need to be in the hospital, and what other medical milestones needs to be met before discharge, Rossi adds.

The entire team has to be engaged for the process to work, says **Patricia Hines**, PhD, RN, managing director for Novia Strategies, a national healthcare consulting firm.

The team should review the plan of care, what needs to happen that day, determine what indicators physicians are looking for in order to progress the patient along the continuum, and what the barriers are to discharge. They should determine what the patients will need for discharge, and assign someone to address discharge needs, she says.

"Most case managers can identify what the barriers are. They know the organizational challenges and can discuss them in the daily meetings," Hines adds.

Rounds on complex patients should include every clinician who cares for the patients, including representatives from therapy, nutrition, pharmacy, chaplaincy, and finance counseling, Rossi says. Look at the patients' financial situations and what payers they have and make sure the plan of care takes into account all of the barriers to a successful discharge so that there are no surprises on the day of discharge.

"Complex rounds are crucial, especially for drilling down to find the causes of readmissions. The team needs to take a close look at the cause and come up with ways to prevent the patient coming back," she says.

As she consults with hospitals across the country, **Toni Cesta**, RN, PhD, FAAN, partner and consultant in New York-based Case Management Concepts, hears a lot of excuses for not having multidisciplinary rounds.

"People say they don't have time, but rounds actually save time. The nurses, case managers, and other participants are giving up less than 10 minutes a day and they learn a lot about the patients that isn't in the medical record. It also saves the time they waste trying to find physicians and other staff to ask questions," she says.

Once the rounds are up and running and the team is hardwired, the participants find that the rounds save time because everyone is getting the same information at the same time, she says.

For rounds to be successful, hospitals have to invest the time to develop a structure for the rounds, educate staff on how to participate, and measure performance, Maslan says.

Start by determining what team members need to attend rounds and what contribution each can have. Then get buy-in from the heads of all departments involved, Cesta says.

Map out your goals and outcomes for the rounds and get the support of the chief nursing officer and the physician advisor, Hines advises.

Set a firm time and place for the rounds and make them mandatory, Cesta says. Then have mini rounds in the afternoon and go over everything you identified in the morning, she says.

Stagger the times each unit holds rounds so staff such as pharmacy,

dieticians, and therapy that cover several units can be present, Maslan says.

Rounds should be led by a facilitator, often the charge nurse on the unit. "If there isn't a designated charge nurse, a case manager is a good backup. Case managers work across all disciplines and can bring a broad view of the patient," Maslan says.

Structure rounds to give each team member time to have input, Rossi recommends. Alert participants ahead of time so they can prepare, she adds.

"It's very important to have a structure with talking points from each discipline. The direct care team has to be present for these rounds. If the rounds are just nurse-to-nurse or nurse-to-physician reports, it's not beneficial for everyone," she says.

In order for the rounds to be successful, they have to be meaningful for the participants, Maslan says. "Strong, consistent leadership is crucial. If you don't have that, you won't get buy-in from the team," she says.

After rounds have been in place for a while, conduct audits to determine how successful you are at starting rounds on time, whether the entire team attends, how discharge barriers are addressed, and how you are doing in meeting your performance improvement goals, Hines suggests. ■

Justifying short inpatient stays just got easier — or did it?

Status is based on physician judgment

The Centers for Medicare & Medicaid Services (CMS) has modified the controversial two-midnight rule to allow shorter stays to be billed as inpatient stays based on the physician's judgment, but the change means that complete documentation is more important than ever before.

In the Outpatient Prospective Payment System (OPPS) final rule for calendar year 2016, issued Oct. 30, 2015, CMS said that inpatient stays of less than two midnights will be payable under Medicare Part A on a case-by-case basis. The decision to admit is based on the judgment of the admitting physician.

The new rule maintains the original two-midnight benchmark for inpatient stays but permits greater flexibility for determining that a stay of less than two midnights meets medical necessity criteria for an inpatient stay, says **Debra Primeau**, MA, RHIA, FAHIMA, president of Primeau Consulting Group, headquartered in Torrance, CA.

At the same time, CMS shifted the enforcement of the rule to two Beneficiary and Family-Centered Care Quality Improvement Organizations (QIOs), Livanta and KEPRO, from the Medicare Administrative Contractors (MACs) and the Recovery Auditors (RAs). The QIOs were to begin reviewing the short stays on Jan. 1, 2016. They will alert the RAs if they find patterns of high rates of claims denials after medical review or failure to improve after a hospital has received education.

The new rule may not help clear up the confusion about whether short stay patients should be admitted as inpatients or receive observation services since CMS did not include any guidance about what constitutes a short inpatient stay except to say that it's a matter of physician judgment, says **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services, a Shawnee, OK, healthcare consulting firm.

Stakeholders in the hospital industry had asked CMS to create a one-midnight rule, a suggestion the agency did not take. "Without any specific guidance except the exceptions already given, this change just adds to the confusion," Hale says. Procedures on the inpatient-only list are exempt from the two-midnight rule. Hospitals may be paid for an inpatient admission when patients leave against medical advice, die, or are transferred to another facility and the expectation they would stay two midnights is documented in the record.

The new policy covers stays where the physician expects the stay may be less than two midnights, but the patient needs the intensity of care that falls within the inpatient criteria as set forth by CMS in the new OPPS rule and which is supported by the treating physician's judgment, says **Steven Greenspan**, JD, LLM, vice president of regulatory affairs for Executive Health Resources, a Newtown Square, PA, healthcare consulting firm.

One-midnight inpatient stays should not be confused as being an exception under the CMS rare and

unusual exception policy, Greenspan says. CMS continues to list only new mechanical ventilation as a case that qualifies for a short inpatient stay under the rare and unusual exception policy, he adds. "CMS specifically stated in the final rule, 'We would like to clarify that our proposed modification to the current exceptions process does not define inpatient hospital admissions with expected lengths of stay less than two midnight as rare and unusual,'" Greenspan says.

The changes in the rule make it more important than ever for case managers to review every patient record at the point of entry to ensure that the physician documentation supports patient status, based on the inpatient admission criteria the hospital uses, Primeau advises.

"The documentation requirements haven't changed. Patient status is still based on whether or not a patient should be there on an inpatient basis, regardless of the length of stay. The documentation needs to make it clear that the patient's condition warrants inpatient care rather than observation services as an outpatient, including a list of all the reasons a patient requires an inpatient stay," she says.

Case managers should pay careful attention when the expected stay is less than two midnights to ensure that the medical record has robust documentation of clinical factors that warrant an inpatient stay, adds **Kurt Hopfensperger**, MD, JD, senior medical director of audit, compliance, and education at Executive Health Resources.

"For a one-midnight stay to qualify for reimbursement as an inpatient admission, the documentation must include medical history, comorbidities, details on the level of intensity of the care needed, the level of severity of illness, and the risk of an adverse event and all of them must support an inpatient stay," Hopfensperger says.

Case managers should also make sure that the admission order is signed by a physician with admitting privileges before the patient is discharged, Hale says.

"The requirement for the admission order to be signed before the patient is discharged by a physician with admitting privileges has caused all kinds of nightmares and some denials. In many hospitals, emergency department physicians do not have admitting privileges and can't sign the admission order, but the electronic order entry system does not have a way to flag the emergency department physician orders that require a co-signature by the admitting physician. That's where case managers can help with compliance," Hale says.

Many hospitals are incorporating utilization review documentation improvement opportunities into the role of clinical documentation improvement specialist who looks at medical necessity as well as making sure the documentation reflects severity of illness and clinical treatment, Hale says. "They aren't taking over the role of the case manager, but making it a team effort," she adds.

CMS has stated that stays of less than one midnight will have the highest priority for medical reviews but has not announced whether all one-midnight stays will be reviewed or whether the MACs will conduct prepayment reviews on one-midnight stays, Greenspan says.

Every case the QIO denies will be referred to the MAC for recoupment. If hospitals have an unacceptably high denial rate, they will be referred to the Recovery Auditors.

CMS will provide the QIOs with a list of hospitals with eligible claims for one-midnight stay reviews. These reviews will be limited to a total of 20 a year, or 10 every six months for small hospitals and up to 50 cases and a maximum of 25 every six months for larger hospitals, Greenspan says.

CMS says payment for stays of less than two midnights is going to be decided on a case-by-case basis and will be based on the clinical judgment of the medical reviewer who may or may not use commercial utilization tools, clinical requirements

EXECUTIVE SUMMARY

In the Outpatient Prospective Payment System final rule for 2016, the Centers for Medicare & Medicaid Services modified the two-midnight rule to allow shorter stays to be billed as inpatient stays based on the judgment of the admitting physician.

- CMS shifted enforcement of the rule to two Beneficiary and Family-Centered Care Quality Improvement Organizations, which will alert the Recovery Auditors if they find patterns of high rates of claims denials.
- CMS did not include any guidance about what constitutes a short stay except to say that it's a matter of physician judgment.
- Case managers should review every patient's records to ensure that the physician documentation supports an inpatient admission and that the admitting order is signed by the admitting physician before the patient is discharged.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

Interdisciplinary Walking Rounds: A Key Strategy for Improving Case Management Outcomes – Part 2

By Toni Cesta, Ph.D., RN, FAAN

Introduction

In last month's edition of *Case Management Insider*, we began exploring the evolving world of interdisciplinary care rounds. "State of the art," as defined by The Joint Commission and the Institute for Healthcare Improvement, is to have some form of bedside or walking rounds. These bedside rounds provide a mechanism for engaging not only the entire healthcare team, but also the patient and family, in the planning process. In order for rounds to be most effective, they must include a script that all team members are familiar with. By using a script, the rounds are more likely to stay on track and within the time allotted. Last month we reviewed the "talking points" for such rounds, including the specific elements to be discussed. This month we will continue our discussion of rounds, including the roles of specific team members.

Daily Goals

One element of the rounding process is to develop, revise, or complete components of the patient's plan of care. The care planning session that takes place on rounds includes a discussion of the patient's daily goals. Daily goals provide a framework for the team and for the patient in terms of management of the patient's progress toward their goals and toward discharge. The process should take place as follows:

- determine the key goals for that day,
- document the goals so that they are readily accessible to the care team, the patient, and the family,
- provide feedback and reflection on the progress toward the goals every day,
- revise/reset the goals as needed based on the team's review, and
- update the patient and family.

Engaging the Patient and Family

One of the most powerful differences between bedside rounds and rounds that take place in a conference room is the opportunity to include the patient and family in the process. This is the most significant difference between these two types of rounds. Before including the patient or family in the rounding process, it is advised that, whenever possible, you orient them to the process first. During an orientation discussion, you should discuss the focus of the rounds. Explain that the rounds are used as an opportunity for the healthcare team to meet with the patient and family and discuss the daily goals and goals for the hospitalization. It also provides an opportunity for the patient and family to ask any questions or get any clarification they might need regarding any components of the healthcare plan.

> ONE OF THE MOST POWERFUL DIFFERENCES BETWEEN BEDSIDE ROUNDS AND ROUNDS THAT TAKE PLACE IN A CONFERENCE ROOM IS THE OPPORTUNITY TO INCLUDE THE PATIENT AND FAMILY IN THE PROCESS.

The next area to be discussed during the orientation discussion should be the routine, or how the healthcare team will present themselves at the bedside. Finally, the expectations for rounds should be explained. The patient and family should understand that rounds last for about 60 to 90 seconds. Should the patient or family need additional or more in-depth information, someone from the team will return to the patient's room after the conclusion of rounds. They should expect each team member to provide some information on their care, or a single representative will speak, depending on

how your hospital structures the rounds.

Entering the Patient Room

The day and time of the rounds should be posted in the patient's room. When the team enters the room they should always start with a brief introduction that includes names, titles, and the purpose of rounds. The patient and family should be encouraged to participate.

Preparing and Attending Rounds

Each member of the care team plays a distinct role on rounds. That role begins with preparation prior to the start of the rounds each day. On page 9 is a table outlining each team member's pre-rounds, rounds, and post-rounds responsibilities.

Talking Points for Rounds

The team should understand their roles on rounds and the focus of their contribution to the patient discussion. Rounds must be mandatory and take place at the same time each day. Below are some examples of talking points for team members:

The Physician and/or Staff Nurse

- the plan of care;
- the expected outcomes of care;
- the expected length of stay;
- discharge plan;
- barriers to care.

RN Case Manager

- status of discharge plan;
- barriers to care and to discharge;
- any reimbursement issues;
- the expected length of stay.

Social Worker

- any psychosocial issues;
- any barriers to discharge.

Respiratory Therapy/Physical Therapy/Nutrition

- any interventions and goals of care;
- any barriers to care.

Respiratory therapy, physical therapy, and nutrition team members should participate on rounds on patient care units where their specialties are areas of focus. For example, physical therapy should participate on units such as orthopedic surgery, neurosurgery, and geriatrics. Respiratory therapy should be active on units where there are ventilators or where respiratory patients are cohorted. Nutrition should be active on long-term units and geriatric units.

Documentation of rounds must take place in a timely manner, meaning either during rounds or immediately afterward. The best way to accomplish this is to use some standard format such as a checklist.

The Impact of Interdisciplinary Care Rounds

In addition to the rewards associated with bringing care planning to the bedside, rounds can have other equally important positive effects. Below is a list of many of the elements that can be improved via an effective rounding process:

- improved communication and teamwork across caregivers,
- reduced duplication and redundancy,
- reduced length of stay,
- improved patient flow,
- reduced errors,
- expedited discharge planning,
- increased collaboration and satisfaction among all members of the team, and
- improved knowledge of the patient's care plan.

These positive outcomes can have an effect on your hospital in a number of categories. Among these is the Medicare Spending per Beneficiary measure, which scores the hospital based on length of stay and cost per case for selected diagnoses. By improving communication and reducing duplication and redundancy, cost reductions can be achieved. In addition, cost can also be positively affected by improving patient flow and reducing errors. Rounds have also been shown to reduce errors in medical ordering due to increased communication and collaboration. The team can also discuss readmission root causes and create a plan of action to reduce them for the patient. While this outcome has not yet been measured as it specifically relates to rounding, enhanced communication in general has been shown to reduce readmission rates.

Case management roles can be equally enhanced by an effective rounding process. When collaboration is improved among all caregivers, avoidable delays can be reduced. At the same time, length of stay can be positively affected. Finally, due to the improved communication among and between team members, the discharge planning process can be expedited with fewer delays in the process. In fact, all of the expected outcomes of an improved rounding process will have a positive impact on case management and the work of case managers.

While these positive effects are undeniable, there are other outcomes that may be more easily measured. These indicators can be tracked on a "rounding dashboard" or "report card" so that team members can see the positive effect that the new rounding process is having. The following is a list of such indicators:

- length of stay;
- ICU patient days;
- ventilator days;
- number of pharmacy changes such as discontinuing antibiotics;
- patient and family satisfaction;
- number of discharge delays.

Someone on the team will need to keep track of these outcome measures and populate the dashboard. A monthly accounting is best, as more frequent measurements will not show enough change. With less frequent accounting, the team will not be able to change processes should the data indicate a lack of improvement in a

	Pre-Rounds	Rounds	Post-Rounds
Provider	• Listen to last 24-hour patient update. • Discuss working diagnosis. • Enter any patient orders. • Review preliminary plan for discharge, meds, tests.	• Sit next to patient. • Introduce team — name and discipline. • Interview patient and get his/her story. • Discuss plan of care, test results, next steps, other recommendations. • Answer any questions.	• Enter orders, clarify any issues. • Enter progress notes or dictation. • Call consulting physicians, family regarding test results. • Summarize expectations to team members.
Resident	• Present patient case to attending physician/team. • Update team on patient conditions. • Give recommendations for plan of care. • Enter any orders, including medications.	• Support attending physician during assessment. • Help answer any questions.	• Enter orders as needed for patients. • Enter progress notes. • Call consulting physicians as directed by attending. • Discuss med rec with pharmacist.
Staff RN	• Review patient progress over past 24 hours. • Focus on any abnormal findings. • Review any patient/family concerns. • Identify any barriers to patient discharge. • Review any issues such as activity, Foley, IV, wound vac.	• Bring laptop or other device to patient room. • Listen to conversation with patient. • Ask/answer questions from patient and team. • Note orders to be placed later.	• Verify orders. • Discuss and implement medication monitoring. • Make decisions about any remaining concerns. • Document outcome of rounds.
Case Manager	• Review admission status — inpatient vs. observation. • Review case management admission assessment. • Review initial discharge plan and insurance. • Review expected length of stay and discharge date.	• Discuss expected length of stay and discharge day. • Discuss discharge plan — or updated plan — with patient and family. • Identify any additional patient education needs. • Identify any social work triggers for referral to social work.	• Clarify next steps based on patient's goal achievement. • Document any changes to discharge plan. • Refer to social work as needed.

Registered Nurse	• Review daily progress notes. • Review medication profile, medication history, and med rec. • Review PRN med use. • Discuss medication concerns and abnormal lab/ culture findings.	• Listen to conversation. • Ask/answer any patient questions. • Note orders to be placed later.	• Verify orders. • Discuss and implement medication monitoring. • Make decisions about any remaining med concerns. • Document progress notes.

particular area. Your hospital may want to add additional or other indicators to your dashboard depending on the original goals that you set for your rounding process.

Other Measures to Hold the Gain

It is critical that the team stay on track and in order to be sure that they are, there are other measures to manage as well as those mentioned earlier. Administratively, someone should do a periodic monitoring of the following:

- number of days per week that rounds occur,
- number of disciplines involved,
- percentage of patients with a documented daily goal in their record,
- the average time spent with each patient, and
- start time.

These measures are critical to the ongoing success of the rounds. Any of these elements can sustain slippage if not routinely monitored. For example, the start time may begin to get later and later, or some disciplines may stop attending. The time spent with patients may get too long over time if team members go off-script. This type of monitoring should be done by the discipline administratively responsible for rounds. This may be nursing, hospitalists, or others. It may be better to have someone who doesn't typically attend rounds perform this assessment. This fresh set of eyes may pick up issues that those attending on a daily basis may not pick up, or may not be aware of. This can be done ad hoc and should not be scheduled or announced.

The Ultimate Goals of Bedside Rounds

Healthcare continues to struggle with wide variation among providers, hospitals, systems, and states. Variation leads to increased cost and reduced quality of care. By having the team rounds together, each team member can understand and aim to reduce variation in terms of how they manage their patient care and how they deliver that care. In addition, the handoff of communication should be seen as a tool that professionals use to ensure that patient care is not duplicated and that things do not fall between the cracks. Good communication is every professional's responsibility. Finally, it is during handoff communication that issues of quality of care, such as delays, can be caught early and addressed in a timely manner. These kinds of vulnerabilities will affect cost and quality but can be caught early during rounds. Ultimately, it is the engagement of the patient and the family that makes bedside rounds a winner. Lack of communication is a leading cause of dissatisfaction for patients. It leads to errors and to readmissions when patients are not informed and/or do not understand the role that they need to play in their own care.

Transitioning to Walking Rounds

The best way to make a smooth transition to walking rounds is to leverage your existing rounds. You may have rounds in a conference room that work well and are well attended. You can take this format to the bedside and utilize the parts of the sitting rounds that were working well. Or you may have a good walking rounds process already in place in some hospital locations such as the critical care units. In either case, take the best of what you have and use it as a strategy to bring your rounds to the patient bedside. Be sure to include all stakeholders in the planning and implementation process. Start slowly and add units over time. Pick initial units that you think will be successful early on. Early success will motivate other units to want to participate as well. Roll them out as quickly or as slowly as you think will work best, but keep the momentum going!

Summary

The role of interdisciplinary care rounds has never been more vital to the success of healthcare institutions. As the Centers for Medicare & Medicaid Services continues to strive to equate reimbursement with quality of care, hospitals will need to find new ways to deliver care that achieve these goals and have a positive effect on the bottom line. The notion of rounds is not a new one, but taking rounds to the bedside on all patient care units is. Critical care areas have used this format for years, but it is now time for this effective process to be taken to the bedside of each and every hospitalized patient. ■

information, or medical literature, Greenspan says.

"CMS has steadfastly maintained that it doesn't endorse screening tools and auditors can choose whether to use them or not. Both of the QIOs have said they will use InterQual criteria and if the case doesn't meet InterQual criteria, it will go on to physician review," Hopfensperger says.

"The good news is that the rules haven't changed much. Even better news is that the QIOs are reviewing short stays. Unlike the RAs, the QIOs don't get paid on a contingency fee so there is not the same incentive to routinely deny cases," Primeau says.

By giving the responsibility for reviewing claims to the QIOs, CMS is returning to the processes it used when the DRG system was first adopted and the QIOs (formerly known as the PRO) reviewed claims for medical necessity, Hale says.

When the QIOs conducted medical necessity of admission reviews in the 1980s and 1990s, reviews included screening with medical necessity criteria but claims could not be denied unless a physician agreed that inpatient status was inappropriate, she said.

"If the QIOs use that methodology, everyone should happy. If they use the method the RAs used and a nurse or a non-clinical person conducts the reviews without physician involvement, there are going to be a lot of complaints," Hale says. ■

CMS launches mandatory joint replacement bundled payment initiative

Program starts April 1 in 67 geographic areas

Beginning April 1, approximately 800 hospitals in 67 geographic areas will begin participating in the first mandatory Medicare bundled payment initiative.

The Comprehensive Care for Joint Replacement payment model holds hospitals financially accountable for the cost and quality of care delivered to Medicare fee-for-service beneficiaries for hip and knee replacements from surgery through recovery.

All hospitals in the selected geographic areas that are paid under the Inpatient Prospective Payment System are required to participate and will bear risk for the costs of hip and knee replacement surgery from the time of surgery through 90 days after discharge. Hospitals that are already participating in Models 1, 2, or 4 of the Bundled Payments for Care Improvement initiative are exempt from the program.

The five-year program begins with admissions on or after April 1, 2016. CMS originally proposed starting the program Jan. 1, 2016, but postponed the beginning of the first performance period after feedback from the healthcare stakeholders. It cut the number of geographic areas included in the pilot from 75 to 67.

Hospitals will continue to be paid under Medicare's fee-for-service system. Beginning at the end of the second year, hospitals may receive an additional payment or have to repay Medicare for a portion of the Medicare spending for hip and knee replacements. The bonus or penalty will be based on the hospital's success in meeting a target episode price for each DRG and performance on two quality measures in the Hospital Inpatient Quality Reporting Program — Surgical Complications, Total Knee and Total Hip Arthroplasty, and the patient experience measure on the Hospital Consumer Assessment of Healthcare Providers and Services (HCAHPS).

In a news release announcing the final rules for the program, CMS pointed out that the rate of complications such as infections and implant failures after joint replacement surgery is more than three times higher at some facilities than at others with the average Medicare expenditures for surgery, hospitalization, and recovery ranging from $16,500 to $33,000.

"The Comprehensive Care for Joint Replacement (CJR) model addresses low quality and high costs that come from fragmentation by promoting coordinated, patient-centered care. When approaching care without seeing the big picture, there is a risk of missing crucial information or not coordinating across different care settings. This approach leads to more complications after surgery, higher readmission rates, protracted rehabilitative care, and variable costs. These are not the health outcomes patients want," the release said.

For more information on all of CMS' bundled payment initiatives and details on one hospital's joint replacement bundled payment program, see the September 2015 issue of *Hospital Case Management*. ■

ACO teams with post-acute providers for improved care coordination

Care managers attend rounds at SNFs, home health agencies

As part of its efforts to provide better coordinated care to Medicare beneficiaries at a lower cost, the Michigan Pioneer Accountable Care Organization (ACO) at Detroit Medical Center has partnered with post-acute providers and works with them face to face to coordinate care and ensure that patients get what they need in a timely manner.

The ACO was ranked No. 1 in the nation in healthcare savings among Pioneer ACOs in 2014, says **Roger Wiseman**, president of the Michigan Pioneer ACO and senior vice president for population health for the Detroit Medical Center market. "We have been successful in saving in each of our three years in the Pioneer ACO. The savings are due to a lot of factors, but certainly our care management is at the top of the list," he says.

The ACO has forged a close relationship with home care agencies and skilled nursing facilities, Wiseman says. Other initiatives include working closely with hospital case managers, follow-up calls to patients discharged from the hospital or emergency department, and visits from a home health nurse when patients are still in the hospital.

"When our ACO team looked at the whole continuum, we saw that at every point where patients transition, there is a big hole where a critical piece of information doesn't go through," says **Joan Valentine**, RN, MSA, corporate director for transitions in care at the Michigan Pioneer ACO. "We knew we needed to build a collaborative relationship with post-acute providers and communicate as patients transition."

As a result, care coordinators from the ACO attend weekly rounds at the home health agencies and skilled nursing facilities to discuss patients, their care plans, and goals. "Meeting face to face works a lot better than trying to work together over the telephone. Because of the collaboration, we have been able to help patients get what they need," Valentine says.

In the early days of the ACO, the organization's team met with the owners of the five largest skilled nursing providers that control 60-plus skilled nursing facilities in the area to talk about ways to coordinate care. "We know patients are readmitted from skilled nursing facilities frequently and we wanted to work with the facilities to prevent the unnecessary readmissions. The multidisciplinary rounds give us an opportunity to collaborate to meet patients' needs and move them along the continuum in a safe manner," she says.

When patients are facing a long stay in a skilled nursing facility, the team looks for ways to move the patient along and preserve their Medicare benefits.

"The skilled nursing staff often alerts us to patient needs and we can intervene and get them assistance," Valentine says.

For instance, the staff at a skilled nursing home was proposing that a younger man who was extremely obese be transferred to a long-term care facility in part because he couldn't participate in therapy because of his size. He was depressed and had major issues with edema and fluid retention. The ACO team worked with the facility to arrange for a different lift, a different bed, and a larger wheelchair so he could get out of bed and move around. They brought in a nutritionist to work with him on a modified diet.

"He had a huge support system within his church and they rallied around him. We educated them on his dietary needs and told them that bringing in food from the outside was not in his interest," Valentine says.

The patient was discharged to an adult foster care home, lost 100 pounds, and eventually went back to his home with support from home care. "He hasn't been back to the hospital. He used his benefits but we knew that was the right thing. He was too young and mentally acute to give up. Because of the close relationship between our team and the skilled nursing team, we were able to find out what he needed and get it for him," she says.

When patients are ready to transfer home from a skilled nursing facility, the ACO care coordinators make sure the skilled facility and the home health agency communicate and help facilitate the transfer home, Valentine says.

The participating home care agencies agreed to give the ACO's patients priority in scheduling appointments and for their nurses to document in the ACO's medical record, Valentine says.

The weekly multidisciplinary rounds at the home care agencies give

the ACO care coordinators insight into what is going on in the patients' homes and what services the ACO should arrange so the patients can live independently and stay healthy, Valentine says.

"The home care nurses tell us what they are seeing in the home and we work together to leverage community resources. Home health is not always the only answer for all needs a patient may have, but we may not know about their other needs. The home health nurses advocate for the patients and help us understand what we need to do for them," she adds.

For instance, the home health nurse may report that the patient needs housekeeping assistance, Meals on Wheels, or that the caregiver needs support. The care coordinators can alert the social workers to set up the services.

The home care nurses play an important role in medication management for newly discharged patients, Valentine says.

"Patients can't always remember everything they are taking and sometimes the final medication reconciliation just before discharge may not be as accurate as we think. We rely heavily on home health providers to assist us in getting the whole picture," she says.

The home health nurse asks patients to bring out all their bottles of medication and goes over them with patients to make sure they are taking the right thing. "The reality is that what they related at the hospital and what's in the home may be very different," she says.

The ACO receives real-time information on admissions, discharges, and transfers from Detroit Medical Center. "When we find out about an admission, we talk to the hospital case manager and social workers and give them information to help them understand the patient and what the discharge needs may be. We tell them we have been working with the patient, and give them information about the patient's history, their support at home, and the home care agency that has been seeing the patient. In some cases, we may know that patients have been admitted several times to different hospitals and can share information on the services they received," she says.

The organization receives an alert when patients are ready for discharge and arranges for a home health nurse to visit the patient in the hospital before discharge.

> "THE SKILLED NURSING STAFF OFTEN ALERTS US TO PATIENT NEEDS AND WE CAN INTERVENE AND GET THEM ASSISTANCE."

When the team identifies a patient with a chronic disease who seems to be getting worse, a nurse case manager goes to the physician office, meets with the patient, and collaborates with the physician on developing a plan of care, Valentine says.

"We are not only reacting to patients who are already receiving interventions, we are looking for patients who are escalating and helping them learn to control their disease and stay healthy," she says.

Staff at the ACO's call center follow up with patients who have been discharged from the hospital or the emergency department. They use a script and ask specific questions to determine if the patients understand their discharge instructions, if they have filled their prescriptions, if a home care provider has set up an appointment if the service was ordered, and if they have made a follow-up physician appointment.

"If the patient has not made an appointment, we make the appointment for them. When our staff calls, they often can get a visit scheduled sooner than if the patient calls," Valentine says.

When patients sound confused or say they don't understand their treatment plan, they are referred to a nurse who either talks to them or to their caregiver. If they have questions about medication, they are referred to a pharmacist.

"The telephonic staff is like a detective: They try to figure out what the patient needs. There is so much pressure to move patients out of the hospital that there is a lot of opportunity for care coordination when people get home," Valentine says.

When patients visit the emergency department two times within a month, the call center staff calls them to find out what is going on and works on getting the patients community-based resources to help support them. They also inform the patients' physicians that they are using the emergency department frequently.

CMS announced changes to the accountable care organization model last spring, Wiseman points out.

"The accountable care organizations are changing, but what's not changing is the core principal and core belief that care coordination, keeping the patient at the center, and communicating across the continuum of care are the keys to success. These apply whether the patient is covered by Medicare, Medicaid, or a commercial insurer," Wiseman says. ■

Beef up your discharge planning to prepare for new rules

CMS proposes changes in the CoPs

CMS has announced a proposed revision of the discharge planning requirements for acute care hospitals, long-term care hospitals, inpatient rehabilitation facilities, critical access hospitals, and home health agencies.

The proposed changes to the Medicare Conditions of Participation require hospitals and critical access hospitals to develop a discharge plan within 24 hours of admission or registration and to complete the discharge plan before the patient is discharged to home or transferred to another facility.

In addition to creating a discharge plan for all inpatients, hospitals and critical access hospitals must develop discharge plans for patients receiving observation services, patient who are undergoing surgery or other same-day procedures that require anesthesia or sedation, and emergency department patients who have been identified by a practitioner as needing a discharge plan.

The proposed rule also requires hospitals and critical access hospitals to provide discharge instructions for patients who are discharged home and to develop a medication reconciliation process. All providers who are transferring patients to another facility must provide specific medical information to the receiving process.

Hospitals and critical access hospitals will be required to establish a post-discharge follow-up process under the rule.

CMS issued the proposed changes at the end of October with a 60-day comment period. The final rule will be released later in 2016. The document is available online at http://1.usa.gov/1kZzuW4.

More details on the rule and what it means for case managers will be in the February issue of *Hospital Case Management*. ■

Multidisciplinary team brainstorms on transitions for complex patients

Cases are identified early in the stay

At Spectrum Health Butterworth and Blodgett Hospitals in Grand Rapids, MI, patients who are likely to have complex discharge needs are identified early in the hospital stay and referred to a multidisciplinary Complex Transitions Team, which develops a plan of action designed to remove barriers and produce a smooth transition to the next level of care.

Before the initiative started, a multidisciplinary team reviewed the cases of patients who were in the hospital more than 15 days and determined that many patients with long stays were really sick and did not have complex transition needs.

"We looked among our patients to see what population is really complex and determined that they fall into three categories, and many of them fall into two of the categories or all three," says **Tali Harris**, MSN, RN, ACM, supervisor for care management for Spectrum Health/Blodgett Hospital.

Many patients with complex discharge needs have financial issues, no insurance or are underinsured; they have complex medical needs that can't be met in a community setting; and/or they have psychosocial problems with a lack of resources and appropriate settings for placement, Harris adds.

"We did extensive literature reviews, including the Centers for Medicare & Medicaid Services' Conditions of Participation. Over and over, the literature stated that a well-designed discharge planning process takes a team approach and a collaborative partnership with post-acute providers," Harris says.

Members of the Complex Transitions Team include representatives from care management including social workers and nurses, the hospitals' care management supervisors, the care management director, the utilization management medical director, a representative from the hospital ethics staff, representatives from Spectrum Health's post-acute facilities including rehabilitation, home care, and skilled nursing facilities, and a representative from

Priority Health, Spectrum Health's health plan.

Every patient who is admitted is screened by a case manager who completes the initial assessment within the first 24 to 48 hours of admission. The case manager looks at the patient's support system or lack of support, potential post-acute needs, psychological situation, financial status, and history of admissions or emergency department visits. Patients who are likely to have complex discharge needs are referred to the Complex Transitions Team, says **Britt Thompson**, MSN, RN, clinical manager, care management for Spectrum Health.

The Complex Transitions Team meets once a week and goes through the list patient by patient. Team members who cannot attend in person dial in on a conference line.

Individual team members also review the patient charts every day, Thompson says.

The primary case managers for each patient are encouraged to come to the meetings and present their cases. In their absence, the supervisor presents the case.

The team discusses each patient's situation, what has been tried, and what has worked in other cases. "We look at how we can make a difference and each member of the committee looks at the case from his or her perspective. For instance, the ethics representative may ask if what we are suggesting is what the patient really wants. Sometimes we don't have any ideas and the group brainstorms to come up with a creative plan," Harris says.

The members have different clinical backgrounds and different experiences and each brings a very different perspective to the table. Often, they can suggest things that the hospital clinical staff didn't think of, Thompson says. For instance, the representative from a skilled nursing facility suggested an approach to preventing the elderly from pulling out their IV lines with a method that did not involve chemical or physical restraints.

"This intervention has proven to be very effective, facilitated a timely discharge, and ultimately avoided a readmission," Harris says. "It really does take a village to ensure an effective transition," she adds.

The Complex Transitions Team develops a plan of action taking into account the patient's and family's input, she says. The case management supervisor, case manager, and social worker carry out the plan with the help of the rest of the healthcare team.

The team looks for trends that occur repeatedly in the system and brainstorm about ways to improve, Thompson adds. "When we discover a pattern, we are proactive and take action on the issue. We feel like we are making a meaningful difference patient by patient as well as at the system level," she says.

For instance, patients with serious psychiatric illness and complex medical needs are challenging to place and are at high risk for readmission, she says.

"Through the work of our Complex Transitions Team, we determined that these patients needed to be placed in subacute rehabilitation and that we needed to support the facility in managing the patients and not sending them back to the emergency department when they have psychiatric problems," she says.

The team is in the process of developing a pilot project with a skilled nursing facility to provide care for patients with both complex medical and psychiatric needs. "We have been meeting with the upper level leadership from the skilled nursing facility and have brought in our psychiatrists to these meetings," Harris says.

When patients are placed on the Complex Transitions Team list, they stay there forever so the team is informed when they are hospitalized again. "This way, we know to find the history and not start from square one. If the patient is in the emergency department, we can intervene and prevent the admission if it is not medically necessary," Harris says.

The hospitals' emergency departments are staffed by case management social workers 24 hours a day. The emergency department social worker can intervene on an as-needed basis to assist with patients on the Complex Transitions Team list who come into the emergency department.

The case managers may go to see them in the emergency department or call the social worker on duty and explain the patient's situation. The social worker determines what services the patient needs to help avoid a hospital stay. The goal is to connect patients who are high utilizers with support services instead of admitting them, Harris says.

"Our team and its work is ongoing and evolving. It's getting better and better. We have seen a consistent decrease in length of stay and in the future will be adding more service lines, including pediatrics," Harris says. ■

COMING IN FUTURE MONTHS

- What the new discharge planning rules mean for you
- Is the readmission reduction program unfair?
- Having the conversation about hospice, palliative care
- What are the RACs up to now?

HOSPITAL
CASE MANAGEMENT

CNE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

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3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

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5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

CNE QUESTIONS

1. According to Peggy Rossi, BSN, MPA, CCM, a consultant for the Center for Case Management, how long should the multidisciplinary team spend discussing each patient during daily rounds?

A. Five minutes or less.
B. One-to-two minutes.
C. Three-to-four minutes
D. As long as it takes.

2. In the Outpatient Prospective Payment System (OPPS) final rule for 2016, the Centers for Medicare & Medicaid Services said that inpatient stays of less than two midnights will be payable under Medicare Part A on a case-by-case basis and that decision to admit is based on the judgment of the admitting physician.

A. True
B. False

3. As part of its readmission reduction program, care coordinators from the Michigan Pioneer Accountable Care Organization at Detroit Medical Center attend rounds at home health agencies and skilled nursing facilities how frequently?

A. Weekly
B. Monthly
C. Quarterly
D. Whenever they can

4. At Spectrum Health Butterworth and Blodgett Hospitals, every patient who is admitted is screened by a case manager who completes the initial assessment in what time span?

A. The day of admission
B. Within 24 to 36 hours
C. Within 24 to 48 hours
D. At least a day before discharge

HOSPITAL CASE MANAGEMENT

Opportunities, responsibilities are increasing, but what about salaries?

Readers report long hours, small raises

The good news: there are more opportunities than ever before for case managers. The bad news is that, faced with more responsibilities, many hospital case managers are working longer hours but not always getting compensated for it.

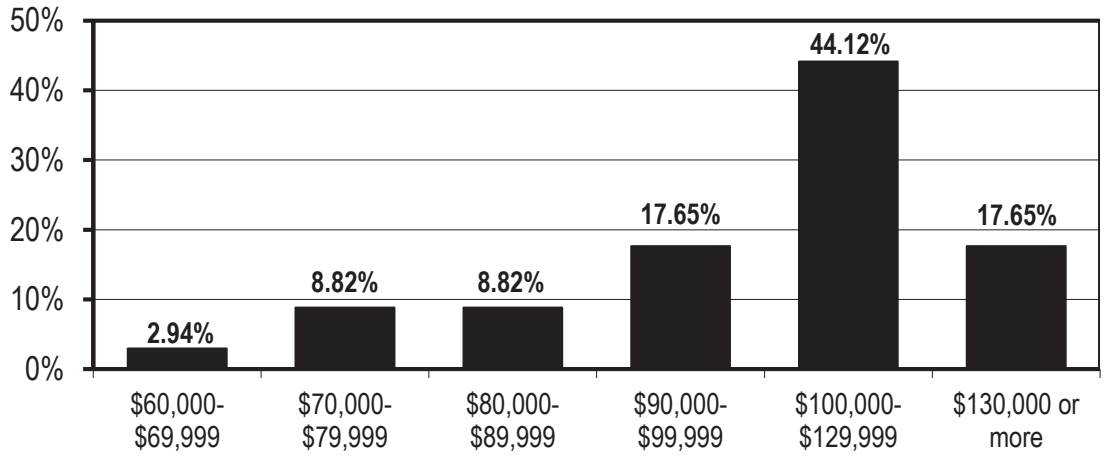
Every respondent to the 2015 *Hospital Case Management* Salary Survey reported working more than 40 hours a week and 38% said they put in 50 hours or more each week. Thirty percent of respondents reported they received no raise last year and half of respondents got a 1% to 3% raise. Just 18% got raises of 4% or more.

However, a recent survey of certified case managers who work in a variety of settings showed that salaries are increasing, says **Patrice Sminkey**, RN, chief executive officer for the Commission for Case Management Certification.

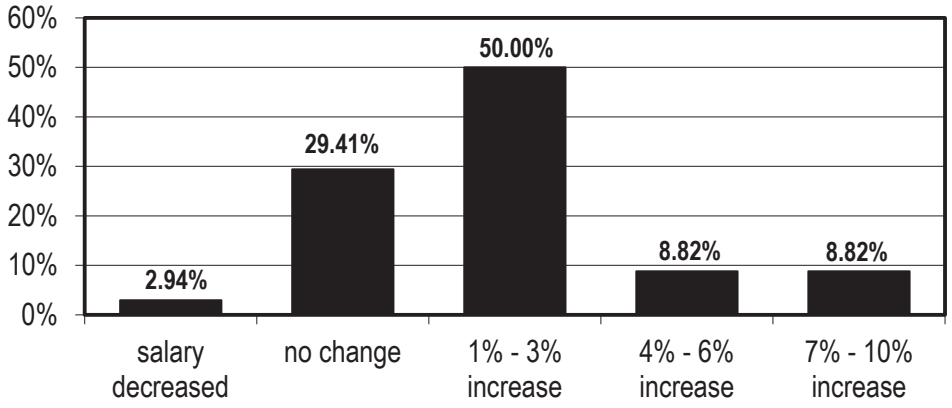
The median salary for certified case managers who responded to the Health2 Resources and CCMC Professional and Demographic Characteristics of CCMs September 2015 survey[1] was $75,000 to $80,000 a year, compared to the 2013-2014 survey when the median salary range was $70,000 to $75,000, Sminkey says. CCMC's certified case managers represent a variety of disciplines including nurses, social workers, pharmacists, and others.

Hospital Case Management readers are older and

What is your annual income from your primary healthcare position?



In the last year, how has your salary changed?



experienced case managers, with the majority of respondents (65%) reporting being over 50. More than three-quarters of respondents (76%) reported healthcare careers of 22 years or longer and a similar percentage (75%) have been case managers for 10 years or longer. They're well educated, with 55% holding a graduate degree.

Although seasoned case managers are beginning to retire, young case managers are taking up the slack, Sminkey says. According to the Health2Resources and CCMC survey, 38% of respondents who have become case managers after 2012 are under age 45.

"Our case managers are getting younger and they're becoming certified earlier in their career," she says.

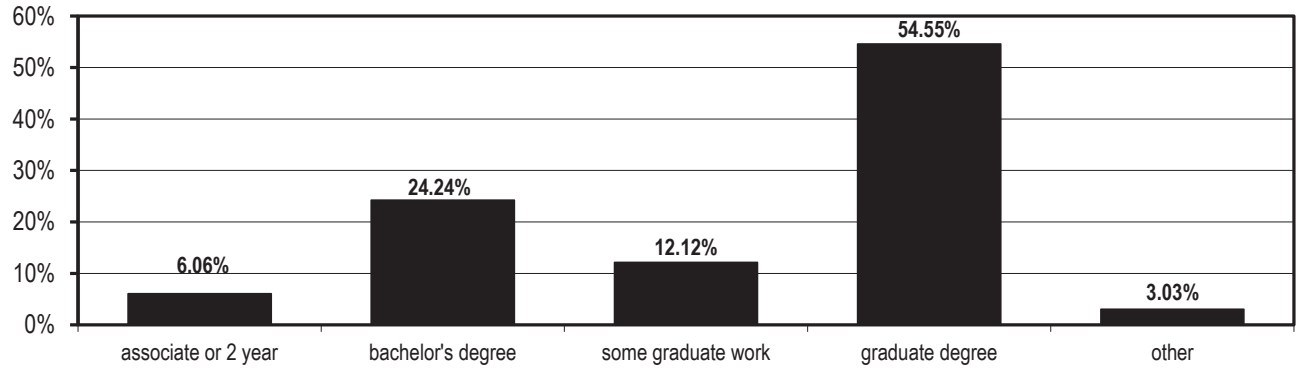
"Hospital leaders are beginning to realize the importance of case managers and social workers. However, although the hours have increased, many times the pay has not," says **Brian Pisarsky**, RN, MHA, ACM, associate director at Berkeley Research Group, with headquarters in Emeryville, CA.

"Regrettably, I think many case managers are working longer hours for the same pay," adds **Catherine M. Mullahy**, RN, BSN, CCRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY, case management consulting firm.

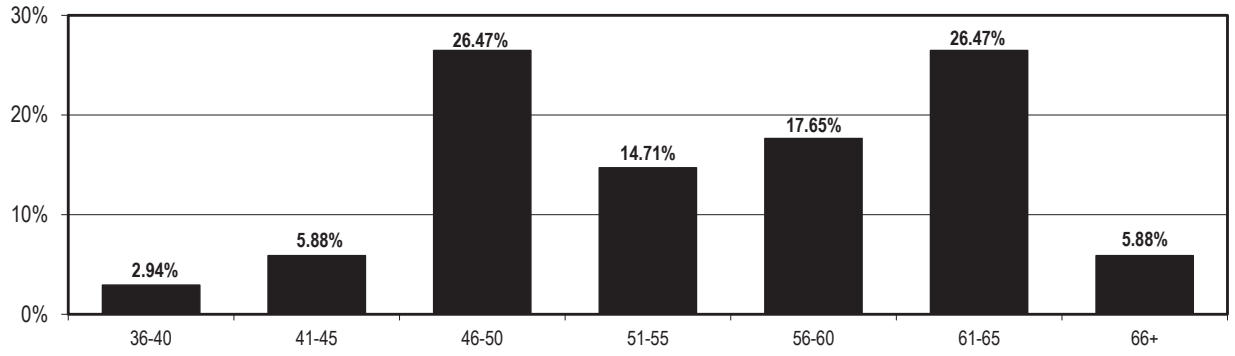
"In some cases, their employer may be taking advantage of their concern for their patients and sense of responsibility for their safety and well-being," Mullahy says.

Pisarsky points out that in many hospitals, case

What is your highest degree?



What is your age?



manager pay is on a par with the pay of nurses.

"The trend is for nurses to work 12-hour shifts for three days a week. But we're finding that case managers, because of large caseloads and daily responsibilities, typically spend 10 hours a day in order to get their job done but they still work five days a week," he adds.

More and more departments are going to hourly pay rather than exempt/salaried payment for the case management staff, an arrangement that allows case managers to be paid for additional hours, says **Beverly Cunningham**, RN, MS, consultant and partner at Dallas-based Case Management Concepts.

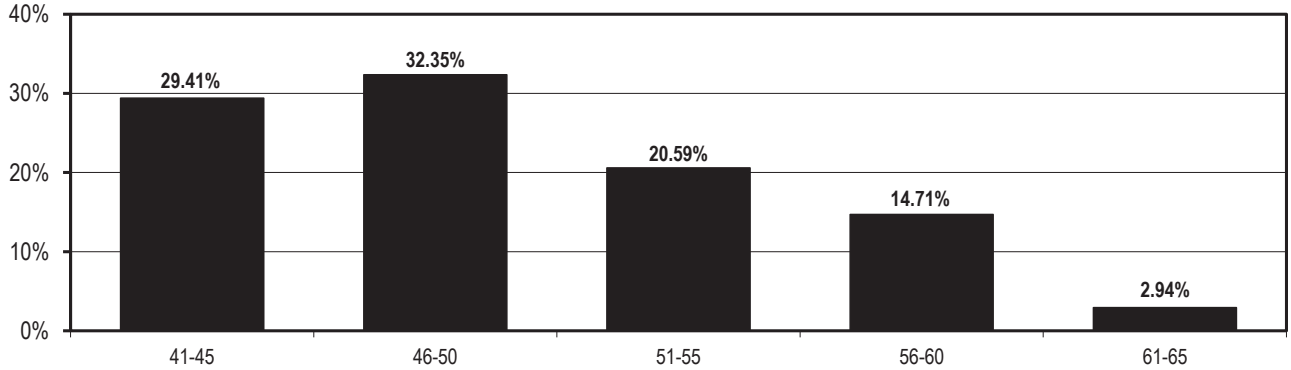
Some hospitals have been proactive and have begun re-engineering their departments to respond to changes in healthcare that have increased responsibilities for case managers, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in New York-based Case Management Concepts. "They are starting to look at across-the-continuum solutions as well," she says.

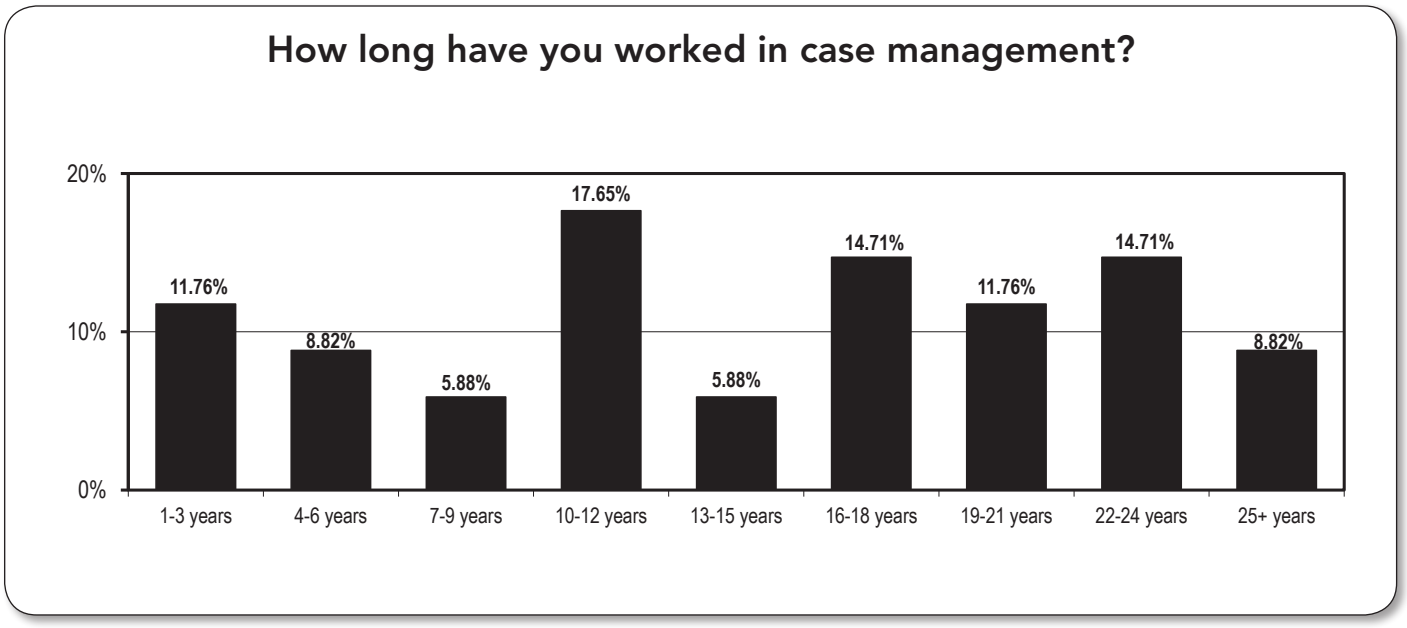
"When the departments are carefully assessed based on current best-practice staffing ratios, many find that they need to add staff, sometimes in large numbers, in order for the department to remain effective," she says.

One solution is to hire case management associates or clerical staff to support the professional work. In addition, there are case management software applications that help make the workload more manageable, she adds.

"It's difficult to recruit case managers and using case management extenders helps significantly," Cunningham says. She advises case management directors to thoroughly evaluate what each member of their staff is doing and determine what tasks are clerical and which require a professional. "Case management

How many hours a week do you work?





directors should have the goal of their professional staff working at the top of their license."

Opportunities for case managers are cropping up in new arenas, thanks to the emphasis on care coordination in the Affordable Care Act, other federal legislation, and regulations from the Centers for Medicare & Medicaid Services and commercial payers that all call for case management, Sminkey points out. "We see ever-growing opportunities for advancement and new career tracks in accountable care organizations, HMOs, physician offices, community-based medicine, and other areas," she says.

The new opportunities, combined with the pressures of the job, may prompt hospital case managers to look at other options for employment, Mullahy says. "When nurses have the title of case manager but find themselves spending more time with utilization review and computer-related tasks, it takes them away from really working with those patients who need their expertise and caring hearts," Mullahy says.

Mullahy points out that the case management standards of practice do not support all of the tasks now expected of hospital case managers. "Those tasks, such as utilization review, observation status, determining the allocation of dollars for bundled payments do nothing to impact or improve the outcomes, care, safety, and satisfaction of patients," she says.

This often leads to turnover as case managers realize that there are other opportunities, she says.

Pisarsky worked with one hospital where several of the case management staff left to work for a managed care plan. "The managed care job was Monday through Friday, the pay was higher, and the benefits were better. But they also said they were leaving because the stress level would be lower," he says.

There is definitely turnover at some hospitals, says Cunningham, who attributes it at least in part to staff who are not ready for the accountability and requirements of the contemporary case management model.

"It's not your momma's case management department anymore," Cunningham says. "These days, case management staff need to have a sense of urgency and work not only efficiently, but effectively," she adds.

REFERENCE

1. Commission for Case Management Certification. CMCoordinates: Charting your professional path. http://ccmcertification.org/cmcoordinates. ■