HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

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Get Ready for Bundled Payments: They're Coming Your Way

Healthcare continues shift to reimbursement based on value

If your hospital is not in one of the geographic areas where the CMS mandated that hospitals participate in the Comprehensive Care for Joint Replacement program, don't think you've dodged the bundled payment bullet.

Bundled payments are not only here to stay, but hospitals can expect CMS to expand them to other markets and other DRGs, says **John W. Malone**, MOD, vice president at Novia Strategies, a national healthcare consulting firm.

Hospitals that are not participating in a bundled payment program, either voluntary or mandatory, still need to start making changes to adapt to the

EXECUTIVE SUMMARY

The fact that the CMS is extending its three-year voluntary Bundled Payments for Care Improving pilot and has launched the mandatory bundled payment project, Comprehensive Care for Joint Replacement, in 67 markets leads experts to conclude that bundled payments are here to stay and will be expanded.

- Bundled payments mean case managers need to manage the length of stay and choice of post-acute options more closely than ever before and make sure that patients receive the most cost-effective and efficient care to meet their individual needs.
- Even if their hospital isn't part of a bundled payment program, case managers should prepare for the future by cementing relationships with post-acute providers and analyzing the variability in cost of care and patient outcomes and identifying opportunities for improvement.
- Relationships with post-acute providers are critical and should go beyond just getting to know the staff, and include sharing patient data.

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new systems of reimbursement, adds **Donna Hopkins**, MS, RN, CMAC, vice president at Novia Strategies.

"We know that the bundled payment train is out of the station and it's not going back. Hospitals not in any bundled payment program may end up being late participants and they need to prepare now," Hopkins says. In addition to the CMS programs, commercial managed care payers are launching their own bundled payments arrangements, she adds.

CMS' latest initiative, Comprehensive Care for Joint Replacement, which went live April 1, is mandatory in 67 markets and covers DRG 469 (major joint replacement of lower extremity with major complications or comorbidities) and DRG 470 (major joint replacement of lower extremity without major complications or comorbidities) from admission to 90 days post-acute.

The first CMS initiative, Bundled Payments for Care Improvement (BPCI), was originally scheduled to be a three-year pilot ending this fall. Current participants have the option of extending their participation for an additional two years, through September 30, 2018. The Bundled Payments for Care Improvement program attracted more than 1,500 participants.

"The extension of the BPCI program for two additional years is a win for both patients and providers as the program has resulted in better coordinated care for the patient, reduced readmission rates, and reduced utilization of skilled nursing, which has enabled more patients to recover in their home environment," says **Deirdre Baggot**, PhD, MBA, RN, principal at ECG Management Consultants and former expert panel reviewer for the Bundled Payment for Care Improvement Initiative. The Congressional Budget Office estimates that bundled payments could save CMS approximately $19 billion between 2010 and 2019, she says.

Bundled payments are popular with providers as well, Baggot says. "Doctors and hospitals are winning with BPCI for the most part, so yes, I fully expect participants to take CMS up on their offer to extend the program through the fall of 2018," she says.

In a survey conducted by ECG Management Consultants, 70% of respondents reported that their healthcare organizations are engaged in some sort of bundled payments reimbursement, she adds. "For hospitals and health systems, bundled payment has a relatively low entry point. It's doable," Baggot says. "And with the Comprehensive Care for Joint Replacement program mandate, most hospital CEOs are coming to the conclusion that it's just good business to be able to effectively compete on both quality and cost. Thus, they have embarked upon readying their organizations for bundled payments and other value-based payment models," Baggot says.

Baggot points out that the cost of healthcare in the United States is double that of comparable nations, despite the fact that the U.S. has the lowest life expectancy and highest infant mortality rate among the wealthiest nations in the world and that the healthcare system is going to have to change in order to survive.

"If we want to revolutionize healthcare, hospitals, physicians, policymakers, and innovators must continue the work that is underway all over this country. With the health of our people and the well-being of our economy

hanging in the balance, this is no time to delay," she says.

The announcement this summer that the Medicare Trust Fund is expected to run out in 2028 means CMS is going to be looking at even more ways to cut costs and improve care, Malone adds.

Bundled payments are just one component of the healthcare market's overall shift to reimbursement based on value, Malone states. In addition to bundled payments, CMS and other payers have rolled out shared savings programs, such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the Quality Payment program as well as the Improving Medicare Post-Acute Care Transformation Act (IMPACT)."They all take a slightly different approach, but their goals are to achieve the same results: higher quality at lower costs," Malone says.

And all of them mean that hospitals have to change the way they do things to succeed in the future, he adds. "Case managers should be looking at the broader context of reimbursement changes across all payers and how it will affect their work," he says.

Bundled payments arrangements are very good in increasing quality and decreasing the costs, says **Brittany Cunningham**, MSN, RN, CSSBB, director of episodes of care for the 1,000-bed Vanderbilt Medical Center located in Nashville, TN, who has spearheaded the medical center's bundled payments initiatives. "They are good for the patient and good for the provider," she adds. *(For details on Vanderbilt Medical Center's bundled payments initiatives, see related article on page 127.)*

Cunningham predicts that in the future, healthcare reimbursement will be a blend of the accountable care organization (ACO) model and bundled payments, with the ACO concentrating on primary care patients, chronic diseases, and bundled payment arrangements for specialty care.

"Bundled payments are not going away. They may blend into other payment arrangements that are based on quality," she says.

CMS is highly likely to expand the mandatory bundled payment program in the future, adds **Graham A. Brown**, MPH, CRC, vice president and practice lead for population health and bundled payments for GE Healthcare Camden Group.

> "THE FACT THAT WE, AS AN INDUSTRY, DO NOT ALREADY HAVE IN PLACE SOME LEVEL OF RUDIMENTARY CARE COORDINATION IS A DISGRACE."

The markets CMS chose for the mandatory joint replacement bundled payments program have a large population covered by Medicare fee-for-service with great variability in acute care and post-acute care lengths of stay, along with variability in costs, disparate outcomes, a high level of complications and readmissions, and poor patient satisfaction scores, Brown says.

One option is for CMS to expand the total joint replacement program to additional markets, particularly those where there has not been significant participation in the voluntary bundled payment program and where there is a high volume of cases and a high level of variability among providers, he adds.

Another possibility is that CMS will add the DRGs that have been most successful in the voluntary Bundled Payments for Care Improvement program, such as cardiac care and bypass surgery, or choose clinical episodes that have been successful in other demonstration projects, he says.

When CMS announced the mandatory bundled payment program, it built in a grace period until January 2017 to give providers an opportunity to develop their program without bearing risk. CMS created the grace period to address concern from people who commented on the proposal that organizations needed time to develop a way to effectively coordinate care for joint patients, Baggot says.

Now, Georgia Congressmen Rep. Tom Price and Rep. David Scott have introduced a bill that would delay the Comprehensive Care for Joint Replacement program implementation until Jan. 1, 2018, to give providers more time to prepare. The bill, HR 4848, has been referred to both the House Ways and Means and House Energy and Commerce committees.

"The fact that we, as an industry, do not already have in place some level of rudimentary care coordination is a disgrace," Baggot says.

The Comprehensive Care for Joint Replacement program is similar to Model 2 in the Bundled Payments for Care Improvement, but is completely separate. The program is in effect in for every hospital that performs hip and knee replacement in 67 specific markets and places all of the risk on the hospitals. Hospitals' reimbursement will be based on the hospital's historical averages and regional benchmarks.

The program requires hospitals to manage the patients from admission through the end of the care continuum, Malone points out. "Hospitals are taking the biggest risk and they have to take some responsibility in overseeing the plan of care throughout the episode of care," he adds.

Bundled payments require case managers to shift to a totally different way of thinking, Hopkins says. "The program mandates that case managers look at the most cost-effective plan for each patient. They have to manage the length of stay in the acute care hospital more closely and ensure that the patient stays at the lowest level of care possible at the least cost throughout the episode of care," she says.

Case managers are critical to the success of bundled payments, Malone adds.

"Case managers are at the heart of making sure that bundled payments programs are effective from an outcomes, an operational, and a cost perspective. If hospital leadership hasn't come to case management yet, the department leadership needs to learn what is happening in their hospital and become a part of it," Malone says. At the end of the day, case management is going to be responsible for the entire care continuum and how that is orchestrated without additional silos and fragmentation will be key, Hopkins says. "Case managers' responsibilities are going to extend outside the walls of the hospital," she adds.

Editor's note: As this issue went to press, CMS proposed beginning a mandatory bundled payments pilot program for cardiac patients in 98 metropolitan areas beginning July 1, 2017. CMS also proposed adding hip and femur fractures to the Comprehensive Care for Joint Replacement program. ■

Bundled Payments Take a Lot of Work — So You Better Start Now

Success in the program requires new ways of doing things

Creating a bundled payments program is like building an airplane while it's flying, reports **Brittany Cunningham**, MSN, RN, CSSBB, director of episodes of care for Vanderbilt Medical Center in Nashville, TN.

CMS has given providers only a short time frame in which to go live with their bundled payments programs — which makes it difficult for providers, adds Cunningham, who has spearheaded the medical center's bundled payments initiatives. "To be successful with bundled payments requires a culture change. It takes at least 18 to 24 months to get everything in place, and that's why it's so hard," she says.

Cunningham advises hospitals that have not yet begun bundled payment programs to prepare by creating initiatives to decrease variation and increase efficiency.

"This will serve hospitals well when they participate in bundled payments, and it's what providers should be doing anyway to improve care for the patient and the bottom line," she says.

The frontline staff, including physicians, should be involved in development of a bundled payment program. Get their input in creating the program, and make sure they buy into the changes, Cunningham says.

Succeeding under a bundled payment arrangement requires a change in culture, says **Teresa Gonzalvo**, RN, BSN, MPH, CPHQ, ACM, vice president for care coordination for Sentara Healthcare, with headquarters in Norfolk, VA. *(For more on Sentara's bundled payment initiatives, see related article on page 129.)*

"Change is never easy. The entire healthcare team, including the physicians, care managers, and post-acute facilities, have to change the way we do things," she says.

"Our primary focus is the continuum of care. The first step for providers is to drop the word 'discharge' from their vocabulary," she says. "We should never 'discharge' patients because that indicates the end of care. We should transition them to the next level of care and make sure their care is consistent as they move from one level of care to another."

Hospitals have a lot of work to do to succeed under bundled payments, says **John W. Malone**, MOD, vice president at Novia Strategies, a national healthcare consulting firm.

"They have to develop relationships and establish dialogue with providers in the community. They also have to develop metrics and measurement systems, come up with protocols for every step of the episode of care, and understand what drives costs across the continuum," he says.

Case managers can prepare for

future bundled payment programs by analyzing the variability in patient outcomes and cost of care and identifying opportunities for improvement. Work on building care pathways that extend to the post-acute environment, and on ways to coordinate care more effectively, adds **Graham A. Brown**, MPH, CRC, vice president and practice lead for population health and bundled payments for GE Healthcare Camden Group.

Case managers have gotten very good at triaging patients to any willing post-acute care provider and getting them out of the hospital as quickly as possible. Instead of looking at the cost of care, their emphasis has been on utilization review and discharge planning, says **Donna Hopkins**, MS, RN, CMAC, vice president at Novia Strategies. "Now, they have to shift to a totally different way of thinking and use their sphere of influence to assess the most appropriate and cost-effective setting for post-acute care," she adds.

Hospitals need to develop a cost-accounting system and determine how the variability in treatment affects cost and outcomes, Brown adds.

Post-acute care is uncharted and where most of the opportunity for savings must occur. This means that in addition to getting patients in the right post-acute setting based on the agreements the hospital made with post-acute providers, case managers are going to have to evaluate the cost of each option and influence provider practice to order the most economical one, Hopkins says.

For instance, it may be more cost-effective to keep a patient in acute care a few extra days and discharge him or her to home with home health, rather than discharging to a post-acute facility. "Emerging navigator roles follow the patient's plan of care into the post-acute setting until the episode has ended," she says.

"Every patient has their own algebraic formula taking into account their conditions, their payer, their home environment, whether or not they have a caretaker, and other factors that could affect their transition post-discharge," Hopkins says. She predicts that assessing the home environment and the availability of a caretaker will take on more importance as "why not home?" becomes the mantra of providers.

Hospitals need to initiate internal reviews to determine the opportunities to refine their processes, Brown says.

INSTEAD OF LOOKING AT THE COST OF CARE, THEIR EMPHASIS HAS BEEN ON UTILIZATION REVIEW AND DISCHARGE PLANNING.

Break down the episode of care into key elements and determine where the variability lies. For instance, look at preparations in advance of the surgery. Is there an educational session so patients are prepared before surgery on what to expect during the recovery period? Does the case manager make sure patients have caregivers to help them after surgery? Do patients understand the purpose of therapy and rehabilitation?

"Hospitals need a standardized tool that incorporates best practices and leads to consistency across all surgeries," Brown says. For instance, in the total joint bundled payments program, hospitals should work with the surgeons to standardize the types of implants used in joint replacement and use quick-recovery anesthesia so patients can be mobile soon after surgery, which leads to better clinical outcomes, he says.

Hospitals also need a tool to track patients throughout the entire episode of care, beginning with the day they are scheduled for surgery and until the 90-day episode is over, Brown says.

"Case managers in the acute care setting need to have the ability to manage care before surgery and at the point of admission and to coordinate with post-acute providers so they know what happens to the patient during the entire 90-day cycle," he adds.

Once the patient has made the decision to have the surgery and the surgeon has set a date, case managers or navigators should begin to engage and prepare patients for what will happen prior to surgery, the day of surgery, each day of their stay, and their potential post-discharge destination, Hopkins says. "Personalized follow-up will need to occur, via a registry process and pathways into the continuum," she adds.

A huge challenge is coordinating follow-up after an acute stay, Hopkins says. "Often, patients get post-discharge calls from the staff nurse, the transition case manager or navigator, the insurance case manager, or even a third-party transitions agency. There are too many people following up and it's confusing to the patients," she says.

"There is a lot of redundancy in healthcare and organizations need to reduce it. Decreasing fragmentation and improving handoffs at transitions is the essence and is fundamental to the goals of the bundled payments initiatives," she says. ■

Provider Partnerships Must go Beyond Collaboration, Include Data Sharing

Contract with organizations with the best track record on quality, readmissions

The significant role that post-acute care plays in bundled payments makes it crucial for hospitals to identify providers that perform the best and enter into agreements with them to establish a high-performing post-acute network, according to **John W. Malone**, MOD, vice president at Novia Strategies, a national healthcare consulting firm.

Malone recommends that case management be part of an executive team that chooses providers with which to collaborate.

Case managers should assess the post-acute providers to which the hospital refers patients and determine which ones historically take the highest number of patients, have the highest quality scores, appropriate nurse-to-patient ratio, best readmission rates, and other quality measures, and work with the administration to develop preferred provider relationships with those who come out on top, suggests **Graham A. Brown**, MPH, CRC, vice president and practice lead for population health and bundled payments for GE Healthcare Camden Group.

Close working relationships with post-acute providers are crucial for hospitals to succeed in today's healthcare environment, adds **Brittany Cunningham**, MSN, RN, CSSBB, director of episodes of care for Vanderbilt Medical Center in Nashville, TN. "The stronger a hospital's relationship with post-acute providers, the more successful the bundled payment initiative will be," Cunningham says.

Hospitals have known for a long time that many of the problems with transitions from acute care to post-acute care stem from lack of communication between providers, Malone says. Building relationships with post-acute providers is extremely important, but it takes more than that. The kind of collaboration that is needed between providers often doesn't exist and has to be developed, he adds.

"Succeeding under a bundled payment arrangement means taking the silos that exist in healthcare and breaking them down. Since hospitals are at risk financially, even when patients are in a post-acute setting they need to be able to provide clinical oversight and measure quality and cost outcomes throughout the 90-day time frame of the bundle," Malone says.

Bundled payments require a different operating model and a different type of relationship with post-acute providers, Brown adds. "The partners need a data exchange so the hospital case manager can know what is happening with the patient in the skilled nursing facility or home health and so that post-acute providers can know what happened during the hospital stay," he says.

Arrangements with partners in the post-acute network must include very clear measures and metrics so hospitals will know what is happening after patients are discharged, Cunningham says.

Hospitals should work with post-acute providers to establish performance measures and use them to monitor the performance of their partners, adds **Deirdre Baggot**, PhD, MBA, RN, principal at ECG Management Consultants and expert panel reviewer for the Bundled Payment for Care Improvement Initiative.

She suggests using measures that include major drivers of costs, such as complication rates, length of stay, and readmissions, and getting the data as close to real time as possible. Other measures, such as patient experience of care, use of ancillary services, and physician utilization, are secondary to the financial effect of the bundle but should be tracked nevertheless, she adds.

Collect and analyze data to show providers and post-acute care partners how their performance stacks up against their peers. Include length of stay, costs, readmissions, readmission penalties, and other pertinent data, Brown suggests. CMS provides hospitals participating in bundled payments with claims data. "Case managers can use this data to show whether a facility or a physician is an outlier," he says.

When it's time for patients covered by a bundled payment arrangement to go to a post-acute provider, the ideal situation is for patients to be treated by a provider that has contracted to be part of the bundle and has an excellent track record for patient care, Malone says.

However, both the Balanced Budget Act of 1997 and Conditions of Participation (COPs) for hospitals, among other sources, guarantee patients the right to freedom of choice, points out **Elizabeth Hogue**, Esq., a Washington, DC-based at-

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

Re-Engineering Your Case Management Department: It's Simple, It's Just Not Easy, Part 2

By Toni Cesta, PhD, RN, FAAN

Introduction

Last time, we discussed the changing healthcare landscape and how it has caused the field of case management to alter its models in order to respond to these changes. The first acute care models were designed in response to the prospective payment system and the diagnosis related groups (DRGs) payment methodologies. Today's healthcare environment poses deeper and more comprehensive challenges than were inconceivable in the 1980s. Our case management models of today and the immediate future require careful design with clearly articulated roles and functions for professional and clerical suppport staff. The staffing ratios for these models must allow for the additional roles and functions that are required in today's acute care setting. These include patient flow, avoidable delay management, outcomes management, and resource management, among others. This month, we will review the elements to be considered when re-engineering an acute care case management model or department.

THIS MONTH, WE WILL REVIEW THE ELEMENTS TO BE CONSIDERED WHEN RE-ENGINEERING AN ACUTE CARE CASE MANAGEMENT MODEL OR DEPARTMENT.

Design Elements

When designing a case management model, healthcare executives must consider the following:

1. Operationalization of the model at the patient level. It must be easy to implement the model at the individual patient level, and patients must be able to realize its effect on their care and outcomes. Some models have been designed in a global, abstract, conceptual sense without any effort to explain how they apply to the individual patient. This leaves the healthcare providers and the case management staff in a struggle, trying to make sense of the model. To eliminate confusion, the conceptual framework of the model must be first redefined at the individual patient or patient care unit level before it is implemented.

2. Systemwide perspective. Refrain from implementing a model that does not apply to all services and to the care of the different patient populations served. It is appropriate and acceptable to slightly modify the model to meet the needs of the different services; however, the basic concepts of the model must be maintained regardless of the patient population (e.g., the presence of a case manager in every service or a case manager/social worker dyad).

3. Redesign of the administrative, clinical, financial, and quality management processes. Because the implementation of case management models means a change in the patient care delivery processes, it behooves the healthcare executives who design and apply these models to redesign the other processes and align them with case management. The processes affected the most are those related to the role of the case manager: transitional/discharge planning, resource allocation and utilization management, and quality and outcomes measurement. This redesign is important because it determines and ensures cost effectiveness and efficiency in the delivery of patient care.

4. Sources of accountability and empowerment. A clear definition of the case manager's role with identified role boundaries, scope of responsibility, and power is an important factor for success in case management. Case

managers who are arbitrarily placed in their roles are set up to fail. Communicating the accountability and responsibility of case managers to all of the departments and staff in an organization is essential for promoting the case manager's power. One way of achieving this is by explicitly identifying the presence of case management as a department, and case managers as a staff, on the table of organization for every staff member to see.

5. Integration of service delivery. Cost savings are achieved by examining the number of departments an organization has and evaluating how each is affected by the creation of the case management model/department. This almost always results in merging and consolidation of departments. If an organization does not merge efforts, fragmentation and duplication will continue and cost savings will not be achieved. The departments affected the most by case management are social work, utilization review, discharge planning, and quality management.

6. Measurement systems. Before implementing case management models, it is advisable to have a measurement system in place. The system must include the outcomes to be measured and must identify the process of data collection, aggregation, analysis, and reporting. A prospective approach to evaluating the effectiveness of the model assists in keeping all involved focused. It also prevents mistakes or unnecessary efforts from being made. The outcomes to be measured must always be driven by the goals and expectations of the model. One should maximize data collection from already existing automated systems, such as electronic medical records and data repositories, cost accounting systems, admitting, discharge and transfer systems, and so on.

Re-Engineering the Case Management Department

The list above provides a framework for the beginning of your case management redesign project. The next step should be the development of a planning committee. This committee should be comprised of the hospital's key stakeholders as well as decision-makers. Members should, therefore, include key physicians, administrators, nursing leadership, case management leadership, and finance department leadership. Other members can be added on an ad hoc basis.

Core Members:

- Physicians,
- nurse leaders,
- case management leader,
- social work leader, and
- administrators.

Ad Hoc Members:

- Physicial therapy,
- medical records,
- radiology,
- pharmacy,
- laboratory,
- acute care case manager/discharge planner,
- health education specialist,
- clinical nurse specialist,
- home care intake coordinator, and
- consulting/specialty physicians.

Once the committee is formed, the group should begin to review all the elements to be considered as they begin the re-engineering process. These would include the following:

- cost implications/budget,
- staff (professional/secretarial/clerical support),
- equipment and supplies,
- table of organization,
- hours of operation,
- reporting structure,
- relationships to other departments,
- policies and procedures,
- information technology/systems, and
- educating the organization.

Cost Implications/Budget: Develop a business plan. The plan should include both personnel and nonpersonnel costs needed to run the department. Consider all staff needed, including professional staff and support staff such as secretarial and clerical. Also, consider equipment needs such as fax machines, photocopiers, and computers. Cost this out as part of the business plan. Set up a budget with the annualized cost of running the department.

Staff (Professional/Secretarial/Clerical Support): Staffing should be based on the role functions to be performed. For example, RN case manager-to-patient ratios will be driven by the functions the RN is performing. If the RN case manager is performing clinical coordination/facilitation, transitional planning, and utilization/quality management functions, an appropriate caseload in the hospital setting would be 1:15. For the social worker, the caseload should be 1:17 patients as identified as psychosocially high-risk. For the clerical support staff, consider one support person to every eight professional staff. The number of case managers and social workers needed can then be calculated based on the bed capacity of the hospital. Other staffing ratios should also be driven by the size of the organization and the functions to be performed.

Equipment and Supplies: The time to budget for equipment and supplies is before the implementation while the budgetary costs are being determined. Consider all functions

being performed and the hardware and software needed to support those functions. Also, consider the management needs and report writing capability when selecting a software package. Other supplies that should be budgeted for include stationery, paper, telephone lines, transportation, and conferences.

Table of Organization/Reporting Structure: Develop a table of organization for the department with a clearly differentiated reporting structure. Consider where the department will fit into the organization and to whom the director of the department will report. Of significant importance is the case manager: The table of organization must clearly state where the case manager's position is and to whom he or she reports. This statement is essential for empowering those who assume the role of case manager.

Hours of Operation: The hours of operation of the department may be driven by budgetary constraints. Decisions will need to be made as to whether the department will operate seven days a week, or will function five or six days. Perhaps you will consider having the ED staff working longer shifts (such as 12 hours) while the inpatient staff work eight-hour shifts. Consider the clinical needs of the organization and the goals of the department when making these decisions. If there is a considerable amount of activity on the weekends, plan for weekend operations.

Relationships to Other Departments: The department may have either formal or informal relationships to other departments in the organization. Consideration should be given to how these relationships will be defined.

Policies and Procedures: A policy and procedure manual should be developed and should include all policies and procedures needed to define the functions of the staff. For example, if utilization management is one of the functions of the department, then all appropriate utilization review policies should be included. Consider any CMS, Joint Commission, or state compliance issues when developing the manual. Include the table of organization and the staff job descriptions, training, and competencies in the manual. Also important to have on hand for use by case managers is a resource manual with contact information readily available, particularly for community resources, volunteer agencies, charity and shelter services, transportation services, and skilled nursing/long-term facilities.

> IF AN ORGANIZATION DOES NOT MERGE EFFORTS, FRAGMENTATION AND DUPLICATION WILL CONTINUE AND COST SAVINGS WILL NOT BE ACHIEVED.

Information Technology/ Systems: If the budget permits, select computer hardware that is state of the art and that will support the functions you are performing both now and in the future. For example, if one of the goals of the department is to eventually become paperless, be sure that your system will support this goal. In terms of case management software products, try to view and test several products before making your selection. Be sure that the software can store and manipulate all of the needed data, especially variance data, for reporting purposes for the department.

Educating the Organization: Before implementation, set up a series of educational programs. Programs should be conducted for case management staff at an in-depth level and for other staff on a less detailed level. Provide additional focused education to the medical staff and administrative staff as needed. Educational programs should be geared toward the needs of the different nursing, medical, and allied health staff.

Developing the Case Manager's Role: Careful consideration must be taken when defining the roles and functions of the case manager. Depending on the roles and functions selected, other departments may need to be restructured or eliminated. Match these to the goals and objectives of the department and the organization. If staff members from restructured or eliminated departments are used as case managers, they should be provided with special training. In addition, conducting team-building sessions for these staff members is advisable to work out any concerns they may have. Examples of roles for the RN case manager include the following:

- coordination and facilitation of care,
- utilization management,
- resource management,
- avoidable delay identification and management,
- transitional planning,
- discharge planning, and
- outcomes management.

Examples of roles for the social worker include the following:

- high-risk psychosocial issue

management, and

• management of psychosocially oriented discharge planning.

Case Manager Specialty Positions: Another issue to consider is the addition of specialty positions. These might include ED case managers and social workers, a discharge planning specialist to manage the most labor-intensive discharge planning issues, or a perioperative case manager to manage patient throughput during the perioperative phase from pre-admission testing to the post-anesthesia recovery unit.

Integration with Other Departments/Disciplines: In some instances, other departments may become integrated with the case management department. Typically, these may include social work and/or quality management. A physician staff member may also need to be integrated, such as a physician advisor. All related departments should be consulted as these decisions are being made, and appropriate staff should be trained accordingly.

Job Descriptions: Job descriptions should be completed before the implementation of the department. As staff are interviewed and hired for these new positions, they should have an opportunity to review the job description and expectations for the position for which they are interviewing. Be sure to include all job functions, skills, performance expectations, and expected outcomes of the position. A job clarification exercise is usually helpful in determining who is best suited to assume responsibility for what functions.

Service Line vs. Unit-Based: The case managers can be assigned to specific product/service lines or clinical areas or be unit-based. They may also be assigned to physician groups or geographical areas, depending on whether your department is in the hospital or in the community. This decision will ultimately drive your staffing patterns and needs. Decisions must be made carefully because of their effect on performance, productivity, and the possibility of ending up with unnecessary unproductive time such as travel time between units, departments, or different locations.

Reporting Structure: A strong infrastructure is important to the success of a case management department. Be sure that the case managers have a clear line of authority and are well-supported as they perform their functions.

Staffing Patterns/Case Loads: A typical mistake made when designing case management departments is to not provide the proper staffing patterns to support the role functions selected. Be sure that the caseloads are not so great that the case managers cannot perform their functions effectively or efficiently. This will surely be a formula for failure. Staffing patterns should also depend on whether you go with service line case managers or unit-based case managers, patient acuity levels, and length of stay.

Hours of Operation: Select hours of operation that best meet the operational needs of the department and the patients. Increase the number of staff at busier times, and decrease the number of staff at quieter times. Consider evening, weekend, and holiday needs. Hours of operation should be adjusted to the needs of different care settings and patient populations.

Variances/Avoidable Delays: A variance identification system should be developed before implementation. Categories of variances such as patient, family, internal systems, external systems, and provider should be selected, as well as a methodology for collecting, coding, aggregating, analyzing, and reporting of variances.

Documentation: Frequency of case management documentation and expected content should be determined and included as a policy and procedure for the case managers. Each organization needs to determine its own specific expectations for documentation. The initial admission assessment can be a standardized form that should be completed on the day of admission. The discharge summary can also be in the format of a standardized form.

Orientation: Curricula for orientation of case management staff, other departments, physicians, and administrative staff should be developed, and education should take place before implementation. This will ensure greater organizational support because the reason for the changes will be understood by all involved.

Goals and Objectives: Departmental goals and objectives should be identified before implementation and included in the educational programs. The goals and objectives selected should be consistent with the vision and mission of the organization. These may include measures of cost such as cost per day/cost per case and measures of quality patient outcomes. All should be prospectively identified and should drive the evaluation of the program.

Summary

In the last two issues, we explored the hows and the whys of re-engineering an acute care case management department. Remember that the models and methods of the past are probably not enough to move your organization into the new era of healthcare. ■

torney specializing in healthcare.

"Many patients, however, do not yet know enough about post-acute services and providers to be able to make choices," she adds.

Hogue reports that in the final rule on the Comprehensive Care for Joint Replacement payment model, CMS stated: "Hospitals, if desired, may recommend 'preferred provider,' that is, high-quality post-acute providers/suppliers with whom they have relationships (either financial and/or clinical) for the purpose of improving quality, efficiency, or continuity of care."

"At the end of the day, hospitals need to honor the ability of patients to choose, but at the same time they can tell patients which providers they have partnered with to manage quality, coordinate care, and track the care plan for the entire 90-day episode of care," Brown adds.

Brown also suggests that when surgeons meet with patients, they give patients the names of post-acute providers the hospital partners with and give patients objective data to support the quality of care.

Sentara Health System divides its list of post-acute facilities into blocks based on algorithms, their quality and safety indicators, and whether they are partners in the bundled payment project, according to **Teresa Gonzalvo**, RN, BSN, MPH, CPHQ, ACM, vice president for care coordination for Sentara Healthcare with headquarters in Norfolk, VA.

"We don't indicate the reasons the facilities are divided that way but if patients ask questions about format, the care manager can tell them the hospital has a relationship with providers in a particular block. The hospital can't steer patients to a particular provider, but we can give them the information that we have a relationship with a post-acute provider," she says. ■

BPCI Initiative Cuts Readmissions, Costs for Patients Having Cardiac Valve Surgery

Program elements replicated for other DRGs

After Vanderbilt University Medical Center began a bundled payment project for patients who had cardiac valve replacement or valve repair surgery, readmissions for those patients dropped by 20% and the cost of care decreased at the same time.

"We still struggle with long lengths of stay in some skilled nursing facilities. The medical center doesn't own any skilled nursing facilities, but we are collaborating with the post-acute providers in the community to work on reducing the stays," says **Brittany Cunningham**, MSN, RN, CSSBB, director of episodes of care for the 1,000-bed medical center in Nashville, TN.

Vanderbilt went live with its first bundled payment arrangement for cardiac valve replacement and repair surgery under the CMS Bundled Payments for Care Improvement model in 2014. After the success of that model, the health system added total joint replacement and stroke to its bundled payments arrangements. The health system was chosen to participate in Medicare's oncology care model program announced by CMS in June. *(For more on the oncology care model, see related article on page 131.)*

The medical center is participating in a total of 11 programs that base payment on episodes of care. In addition to the CMS programs, Vanderbilt University Medical Center participates in Tennessee's Medicaid program that determines payment by reconciling actual costs with a threshold and sharing the savings with providers. Tennessee Medicaid announced the program in 2013 for selected diagnoses and rolled it out in 2015.

The health system leadership chose cardiac valve replacement and repair as the first bundle in the Medicare Bundled Payments for Care Improvement because the department had a strong leadership team, which put them in a good position to test the bundled payment model, Cunningham says.

"The hospital leadership told us that they felt that CMS and other payers were moving toward alternative payment models and it was in our best interest to start testing the model early on," she adds.

The cardiac center created a multidisciplinary team led by the nursing leadership, the physician leadership, and the business leadership in the department to choose a DRG and to design the program.

"When we looked at the data, we saw there wasn't much variation between the patients having a valve replaced or those undergoing valve repair, and the opportunities for improvement were simi-

lar for all DRGs," she says.

The team identified the areas for opportunities, such as reducing readmissions, improving patient education, and adding a care coordination component, and created work groups for each one made up of disciplines that are knowledgeable about, and would be affected by, the changes.

For instance, the work group responsible for creating and implementing a pathway for valve patients was made up of a nurse practitioner, physicians, nurses, and pharmacists.

The team outlined a new care coordination process for patients covered by the bundled payment arrangement and hired two new care coordinators to implement it.

Vanderbilt doesn't have dedicated care coordinators in every area, Cunningham says. "We feel that care coordination can be done by everyone in the clinical team," she says.

However, since the bundle covers an episode of care that lasts 90 days, the team felt that the program needed someone to follow the patients over a long period of time, she adds.

"Care coordination was the only new resource we put into place. When we looked at other components of the program, we determined that we just needed to change the way things were done," she says.

For instance, the team added a mandatory patient education program so patients are prepared for the surgery and the recovery period. The class includes instructions on what to expect the day of surgery, during the hospital stay, and after discharge.

The care coordinators meet the patient for the first time when they attend the education session and complete a detailed assessment of the patient's home situation, support system, and psychosocial needs at that time. "This allows us to start the discharge plan up front, before the patient comes in the door for surgery," she says.

The care coordinator gives the patients a checklist of what they should do before surgery, at the time of discharge, and when they go home.

The care coordinators alert the inpatient team to any psychosocial issues and any barriers to being discharged to home so they will be aware of the problems early in the stay. They work with the social worker on the unit to create a discharge plan.

The care coordinators follow up with patients within 72 hours of discharge and call them a minimum of twice in the weeks following discharge. Most patients receive three or four follow-up calls, Cunningham says.

The team created a follow-up tool that includes questions the care coordinators should ask and allows them to track trends. For instance, if the care coordinator asks about the patient's blood pressure, the electronic tool shows the previous blood pressure readings.

"If the care coordinators are concerned about anything, they work with the nurse practitioner to get the patient back to the clinic. They have had great success in keeping patients out of the emergency department and avoiding readmissions," Cunningham says.

The team created a Stop Light tool that divides signs and symptoms patients may experience into "green," "yellow," and "red" categories and lists what steps the patient should take if his or her symptoms fall into one of the categories. Patients also are asked to wear a rubberized armband with a phone number they can call 24 hours a day if they have questions or concerns.

Following the success of the cardiac valve surgery program, the medical center replicated the process for the total joint replacement and stroke bundled payments arrangements and adapted the process to meet the needs of those patients, Cunningham says.

Before starting the total joint replacement program, a multidisciplinary team analyzed data from CMS and determined that to be successful, the hospital had to reduce overutilization of post-acute facilities for total joint replacement

EXECUTIVE SUMMARY

Vanderbilt University Medical Center's first bundled payment program for cardiac valve replacement and valve repair surgery patients was so successful that the medical center added total joint replacement and stroke to its bundles.

- A multidisciplinary team, led by nursing, physician, and business leadership, looked for areas of opportunity and set up work groups for each component of the program.
- The team designed a care coordination program and the hospital hired two care coordinators who follow the patients from the pre-surgical educational session through post-acute care.
- To meet the goal of reducing overutilization of post-acute facilities, the team created "prehab," a pre-surgical physical therapy program for patients who need it, and everyone who comes in contact with the patients educates them to expect a discharge to home.

patients. "We had to make sure we were sending patients to the right place at the right time, and that meant we had to cut down on the practice of routinely sending patients to a skilled nursing facility for more rehabilitation and to set the right expectations for patients and family members about the discharge destination," Cunningham says.

The care coordinators began informing patients that they should expect to be discharged to home during the presurgical education classes.

"Instead of discussing the possibility of a skilled nursing stay, we talk about a discharge home and educate them on what kind of care they will need when they get home," she says.

Everyone who comes in contact with the patient talks about the discharge to home, she adds. "It hasn't eliminate skilled nursing stays for every patient. We still have some who need to go to a post-acute facility, but we have dramatically increased the number of patients who are discharged to home," she says.

Patients undergoing joint replacement surgery are required to attend an educational class led by the care coordinators before surgery. If they don't attend the class, their surgery is postponed until the education is completed.

The joint team has started what they call "prehab," a program in which appropriate patients have one or two outpatient physical therapy sessions before their surgery.

When patients see the surgeon for a preoperative consultation, the surgeon decides if the patient needs "prehab" or if the educational class will be sufficient. ■

Health System Takes Part in Bundled Payments to Learn for the Future

Program covers 48 DRGs and 12 hospitals

When CMS announced the Bundled Payments for Care Improvement initiative, Sentara Healthcare chose to participate in a big way and now has implemented bundled payments across 12 hospitals, covering 180-plus DRGs.

Sentara decided to take part in the initial voluntary bundled payment program to gain the experience and efficiency necessary to succeed in the future when bundled payments would become mandatory, says **Teresa Gonzalvo**, RN, BSN, MPH, CPHQ, ACM, vice president for care coordination for Sentara Healthcare, headquartered in Norfolk, VA.

"We wanted to stay ahead of the game. We know that eventually these programs won't be voluntary and we wanted to start learning and identifying opportunities before that happened," she says. *(CMS began a mandatory bundled payment initiative for total joint replacement in 67 markets in April of this year.)*

The health system started its program by creating an executive-level steering committee of key stakeholders including physician representatives, the vice president of integrated care management, and representatives from ancillary services, finance, long-term care, and home health.

When the committee analyzed data, it concluded that post-acute care had the greatest opportunity for care redesign and the biggest potential for savings. The committee determined that the biggest gaps occur when patients transition from acute to post-acute care. "Patients need to get their prescriptions filled, have their durable medical equipment delivered, and see their primary care provider for a follow-up visit. These need to be bundled together so all the things that are supposed to be done get done," Gonzalvo says. The goal is for Sentara's pharmacy program, durable medical equipment vendor, home care program, and other post-acute services to work together to provide a seamless transition for the patient.

The team looked at the volume and cost of DRGs and the opportunities for improvement to prioritize the DRGs for the bundled payment. Among the conditions they chose were total joint replacement, spinal surgery, congestive heart failure, acute myocardial infarction, sepsis, pneumonia, gastrointestinal bleed, and esophagitic obstruction.

"We looked at the opportunities within our system, beginning with the acute care stay as well as home care and other post-acute options. We looked at it from a cost savings standpoint, but we also looked at care across the continuum and how to increase quality of care and patient safety. Bundled payments are not just about the cost containment and payment; our goal is to improve care and outcomes for our patients," Gonzalvo says.

The initiative focuses on care

management and how to optimize the function of care managers to best manage the stay of patients.

The health system partnered with an outside firm to manage its bundled payment program and to provide telephonic follow-up and case management during the post-acute period. A systemwide steering committee works with the firm to make sure the programs are in alignment with work flows, compliant with regulatory requirements, and to provide feedback on what is working and what isn't.

When the care managers conduct the initial assessment after admission, they inform the patient and family members that they have been identified as a patient in the bundle. Care managers educate them about the program and alert them to expect follow-up calls from a care coordinator at the outside firm who will follow them for 90 days, provide education, answer questions or concerns, and collect the data needed to assess performance closer to real ime instead of waiting for lagging claims data from CMS.

To make the program more efficient for case managers who are already busy, the health system added a component to its case management software that creates an additional column on the care managers' work list that identifies patients covered by the bundle. Every morning, the analyst from the vendor sends the administrative assistant in each hospital in the system a list of patients in the bundled payment program. The assistant tags them manually in the system.

During daily multidisciplinary rounds, the care manager identifies the patients in the bundled payment program and works with the team to determine the next level of care. "By having this discussion take place during rounds, we make sure everybody is on board," Gonzalvo says.

If the discharge plan calls for a skilled nursing admission, the goal is for patients who are covered by a bundled payment program to go to a "partnering" facility that can meet their needs, and has a good quality and patient safety record and the commitment to work with the hospitals to achieve program goals, Gonzalvo says.

Sentara's involvement with patients continues after they are transitioned from acute care, Gonzalvo says.

Representatives from Sentara participate in multidisciplinary rounds at skilled nursing facilities and home health providers owned by the company. The manager of care management at one hospital talks daily to the director of nursing at one of Sentara's Life Care facilities. "They have a conference call about patients who have been readmitted and what could have been done differently to prevent an unnecessary readmission. We have a pilot to replicate some of their suggestions to determine what is ideal for patients if they are readmitted, starting with our own facilities," Gonzalvo says.

There is another team working on a plan to have providers from the hospital on site at the skilled nursing facility every day and seeing patients on the day of admission. "Depending on the patient's clinical needs, we plan to have a mid-level provider or physician rounding daily at the skilled nursing facility for the first week. Data has shown that the first 72 hours at a skilled nursing facility is a critical time. We want to closely manage the patients and make sure the transition is successful," she says.

Sentara started building relationships with post-acute providers by organizing the Sentara Hampton Roads Long-Term Care Council four years ago. The council includes representatives from the hospital's integrated care management de-

EXECUTIVE SUMMARY

Recognizing that bundled payments were likely to be one way healthcare is reimbursed in the future, Sentara Healthcare in Norfolk, VA, began numerous bundled payment arrangements under the Bundled Payments for Care Improvement initiative so they could gain experience for the future.

- An executive-level steering committee looked for opportunities for improvement and determined that the biggest gaps occur when patients transition from acute to post-acute care.
- The health system contracted with an outside firm to manage its bundled payment program and to provide telephonic follow-up and case management during the post-acute period, and developed a systemwide steering committee to make sure the programs are in alignment with work flows, compliant with regulatory requirements, and to provide feedback on what is working and what isn't.
- Sentara started building relationships with post-acute providers four years ago by organizing the Sentara Hampton Roads Long-Term Care Council, which includes representatives from the hospital's integrated care management department and post-acute providers in the Hampton Roads area, including those not affiliated with Sentara.

partment and post-acute providers including skilled nursing facilities and long-term acute care hospitals in the Hampton Roads area, including those not affiliated with Sentara. The council has about 40 members and meets every other month for educational updates and to brainstorm ways to facilitate smooth transitions.

The purpose of the council is to facilitate the transition of patients from Sentara acute care to long-term care facilities and back to acute care when appropriate and to effectively communicate clinical information as patients transition, Gonzalvo says.

The Long-Term Care Council has a readmissions subgroup, chaired by Sarah Clark, RN-BC, MHA/INF, BSN, CCM, manager of integrated care management education, that includes facilities that are interested in sharing data. The group created a regional dashboard that will be used to share information on readmissions and how facilities handle potential readmissions. The team also analyzes specific patient readmissions, root causes, lessons learned, and opportunities for improvement. ■

CMS Launches Oncology Care Bundled Payment Program

Initiative emphasizes care coordination

Nearly 200 physician groups and 17 payers are participating in the CMS Oncology Care Model aimed at lowering the cost of cancer care by giving physicians financial and performance accountability for episodes of care involving administration of chemotherapy.[1]

Participants are Medicare-enrolled physician groups, including hospital-based practices, that furnish chemotherapy treatment. They are required to provide enhanced services including care coordination and patient navigation to ensure that patients receive timely, coordinated services. Commercial insurers participating in the five-year program will align their oncology payment models with the Medicaid model.

Physician practices will receive a monthly care management payment for each patient in the program, as well as performance-based payments. CMS announced that it will measure quality using patient and practice-related measures and claims-based measures. The quality measures were selected across four of the National Quality Strategy Domains, including Communication and Care Coordination; Person and Caregiver-Centered Experience and Outcomes, Clinical Quality of Care, and Patient Safety, CMS said in a written statement.[1]

In other recent action, in the Outpatient Prospective Payment System Proposed Rule (OPPS) for 2017, CMS proposed eliminating patient satisfaction on pain control measures from value-based purchasing. The agency said it is proposing the change in response to concerns from healthcare providers that the questions about pain management on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) give doctors an incentive to over-prescribe opioid drugs. ■

REFERENCE

1. U.S. Department of Health and Human Services. HHS Announces Physician Groups Selected for an Initiative Promoting Better Cancer Care. June 29, 2016: http://bit.ly/29442Cp.

CE OBJECTIVES

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

1. identify the particular clinical, administrative or regulatory issues related to the profession of case management
2. describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the healthcare industry at large
3. discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

COMING IN FUTURE MONTHS

- Collaborating with community providers
- What Clinically Integrated Networks mean for you
- Tips from your peers on reducing readmissions
- A guide to the latest edicts from CMS

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

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

1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right or log on to AHCMedia.com, then select "MyAHC" to take a post-test.

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%.

4. After successfully completing the test, a credit letter will be emailed to you instantly.

5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CE QUESTIONS

1. CMS has extended the voluntary Bundled Payments for Care Improvement (BPCI) until what date?

a. Sept. 30, 2018
b. Oct 1, 2018
c. Jan. 1, 2018
d. July 1, 2018

2. According to Brittany Cunningham, MSN, RN, CSSBB, director of episodes of care for Vanderbilt Medical Center, how long does it take to get everything in place for a bundled payment program?

a. 12 months
b. 12 months to two years
c. 18 to 24 months
d. It depends on the hospital's processes and culture.

3. According to Graham A. Brown, MPH, CRC, vice president and practice lead for population health and bundled payments for GE Healthcare Camden Group, hospitals can tell patients which post-acute facilities they have partnered with to manage quality, coordinate care, and track the plan of care through the 90-day episode.

a. True
b. False

4. In Vanderbilt Medical Center's bundled payment program for heart valve repair and replacement, how soon after discharge do care coordinators follow up with patients?

a. Within 24 hours.
b. Within 48 hours.
c. Within 72 hours.
d. Within a week.