HOSPITAL CASE MANAGEMENT

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INSIDE

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New Role for Case Managers Opens Up with Payment Reform

Inpatient staff can't handle post-discharge care coordination

As hospitals assume financial risk for what happens to patients during the entire episode of care, responsibility for care coordination can't stop at discharge.

Somebody has to make sure patients have a smooth transition, have everything they need to avoid returning to the hospital, and that the provider at the next level of care has details about the hospital stay. So who's going to do all that care coordination?

Hospitals can't keep piling work on inpatient case managers, says **Jean Maslan**, BSN, MHA, CCM, ACM, senior managing consultant for Berkeley Research Group, with headquarters in Emeryville, CA.

"They already have so much on their plate that they don't have time to give post-acute care coordination the attention it deserves," she adds.

EXECUTIVE SUMMARY

Somebody has to coordinate the post-discharge care now that hospitals are beginning to bear risk for what happens to patients after discharge, but inpatient case managers are already swamped and don't have the time to do the job well, experts say.

- Hospitals need to develop a new role of transitional case manager, RN navigator, or some other title and hire a separate person to handle discharges and follow-up for complex patients.
- The job requires someone with experience in the inpatient setting and knowledge of community resources and how to refer patients to them.
- The key to success under payment reform is communication within the hospital and between all levels of care so everyone who touches the patient has complete information.

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"Case managers can do only so much. In most hospitals, the traditional roles of the unit-based case managers and social workers aren't adequate to handle all of the responsibilities that come from payment reform. It's time to look at the critical needs and create new roles," says **Beverly Cunningham**, RN, MS, consultant and partner at Oklahoma-based Case Management Concepts.

Some hospitals are already establishing new positions to help with the increasing care coordination responsibilities that result from new reimbursement processes.

They're giving the new roles a variety of titles: transitional case manager, nurse navigator, transition manager, transition coordinator, transition coach, or other titles, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts.

"It doesn't matter what people are called. What's important is that hospitals have someone whose main responsibility is facilitating transitions. Handling complex transitions is too much work for the regular staff, particularly since payers are turning more and more to reimbursing for entire episodes of care, which can extend as long as 90 days after discharge," she adds.

Case managers focused on ensuring a successful discharge can have a big effect on bundled payments initiatives, Maslan says. "With bundled payments, hospitals have to share dollars with post-acute providers. If they don't manage patients efficiently, it will have a financial impact. It's in the best interest of the hospital to have a nurse navigator to follow the patients after discharge, which has been shown to cut down on readmissions, repeat emergency department visits, and duplication of services," she adds.

CMS has been progressively adding episodes of care to its bundled payments program since it launched the voluntary Bundled Payments for Care Improvement in 2013. Bundled payment projects for patients with total knee and hip replacements, cancer treatment, acute myocardial infarction, coronary bypass surgery, and hip fractures are either underway or in the works. In addition to the CMS programs, commercial managed care payers are launching their own bundled payments arrangements.

CMS also has proposed major changes in the discharge planning requirements of the Medicare Conditions of Participation that are likely to increase the workload of hospital case managers. Among the requirements are developing a discharge plan for all patients, making follow-up phone calls to all discharged patients, and having discharge instructions in the hands of the primary care provider within 48 hours of discharge. CMS issued the proposed rule in Nov. 2015 and asked for public comments by Jan. 3, but did not set a date for implementation. *(For more information, see the February 2016 issue of* Hospital Case Management*.)*

"If you consider only the bundled payments requirements, hospitals are going to have to develop complex discharge plans for patients with complex needs being transitioned to the next level of care. When you take other payment reform, such as Medicare spending-per-beneficiary and value-based purchasing and the CMS proposed discharge planning rule into account, it sets the scene for every case management leader to begin to consider that transitional

case management role," Cunningham says.

Hospitals need a point person to help coordinate care across the continuum, Maslan says.

"The nurse navigator is the future of nursing. It's an exciting position that has been needed for a long time. The healthcare system is disjointed for many patients. People use the emergency department too much, they miss physician appointments, and often receive duplicate services from different providers. The nurse navigator can guide the patient through the continuum and subsequently save healthcare dollars," Maslan says.

"The nurse navigator's work should encompass the whole patient: psychosocial issues, medical problems, medication, and nutrition," she adds. "They are the point person when the patient needs support with dietary issues, emotional problems, financial needs." When a nurse navigator is coordinating care, patients and family members have one person to contact when they have questions or need help, which increases patient satisfaction, she says.

"Care coordination cannot encompass only the hospital stay anymore," says **Peggy Rossi**, BSN, MPA, CCM, continuity of care service director for the 287-bed Kaiser Permanente Sacramento Medical Center and consultant for the Center for Case Management.

Case management directors should start trying to identify one staff member who can move into the role of complex case manager or inpatient navigator once the role is developed, Rossi says.

"We all need to be taking a hard look at all the changes in the healthcare delivery system that are in the works and start to prepare for them now. Waiting until later could have a dire effect on the hospital's bottom line," Rossi says.

So far, the only mandatory bundled payments initiative that has been implemented has focused on patients receiving total hip and knee replacements. Both are scheduled procedures and most have predictable outcomes, Cunningham says. But the next round of bundled payments are not going to be so simple to implement, she adds.

"CMS' next step creates bundled payments for myocardial infarction, coronary artery bypass graft surgery, and fractured hips. These patients come in through the emergency department and have complex needs that require we take a totally different look how these patients transition to the next level of care," she says.

The next bundled payment program, which is slated to begin July 1, 2017, is likely to be a challenge for all hospitals, but especially for rural hospitals with a high Medicare population, Cunningham points out. "Smaller hospitals may not offer orthopedic surgery or coronary artery bypass graft surgery, but they are likely to have patients come into their emergency department with acute myocardial infarction and fractured hips. Since they will be at-risk for patients for 90 days after discharge, they will need transitional case management," she says.

Hospitals have to focus their efforts on the most complex patients, Cesta says. "Having a transition case manager for every patient isn't practical. Case management leaders need to determine which population of patients need it most," she adds.

Case managers in the new role should have different day-to-day duties from the rest of the case management staff, Rossi says. Case managers in the role should have the time to conduct in-depth assessments and research the appropriate community resources, she says.

"Creating and carrying out a discharge plan for a patient with complex needs is a time-consuming process that can take hours, or even days. The regular case managers often don't have that kind of time, so work may go untouched or it must be assigned to another case manager," Rossi says.

In addition to developing a complicated discharge plan, case managers in the new role will need to educate patients and family members on how to navigate the post-acute healthcare maze, she adds. "This will prepare the patients and family to manage the medical needs that may be long-term or, in some cases, life-long," she says.

To make the case for adding the new position, case management leaders need to be able to demonstrate return on investment to the hospital leadership, Cunningham says.

"Point out all of the initiatives that make it imperative for patients to have an appropriate discharge plan and effective transition to the next level of care. Medicare spending-per-beneficiary, readmission reduction, bundled payments, and CMS' proposed discharge planning rules make it clear that transition case managers are needed," she says.

Analyze data to determine the opportunities for improving transitions and where the hospital can get the biggest value, then try it out with that population. Start with one transition case manager and learn from his or her experiences, Cunningham says.

Maslan suggests piloting the nurse navigator initiative on a high-risk unit, such as one with a lot of heart failure patients, and running the pilot

for at least three months.

"The pilot has to last long enough to produce enough data to track, trend, and make your case to the senior leadership," she says.

Compare outcomes during the pilot with those from the same period of time before the pilot began. Include the cost savings the nurse navigator produced, improvement in quality measures, and patient satisfaction scores, she says.

"Hospitals are already losing revenue when heart failure patients are being readmitted. It is possible to show savings to the hospital after a fairly short period of time," she says. ■

Coordinating Transitions Requires Experience, Knowledge of Resources

Job description should outline specific functions

The role of transition coordinator may be a new one, but it will take an experienced case manager or social worker to handle it successfully, says **Beverly Cunningham**, RN, MS, consultant and partner at Oklahoma-based Case Management Concepts.

"The title and job description for the person who handles transitions will vary from hospital to hospital, but one thing is certain: The person in that position needs to be an experienced professional, either a case manager or a social worker," Cunningham adds.

A transition case manager should have acute care experience and understand how the hospital works and how to connect patients from the hospital and the next level of care, Cunningham says.

It takes a special type of person to coordinate transitions for patients with complicated needs, points out **Peggy Rossi**, BSN, MPA, CCM, continuity of care service director for Kaiser Permanente Sacramento Medical Center and consultant for the Center for Case Management.

"The job is fast-paced and requires a concentrated effort. It's a lot of work for one person. The right person for the job has to be able to work quickly and efficiently to develop the discharge plan," Rossi adds.

Candidates need to have experience in coordinating care for complex patients, understand payer rules and regulations, and be well-versed on what organizations in the community can provide, Rossi says.

"Professionals in this position need to have extensive knowledge of community resources and how to make a referral. They need to know when to make a referral for palliative care and when to get other team members involved," Rossi says.

Depending on the hospital's patient population, the role could be filled by an RN or a licensed social worker, Cunningham says.

In smaller hospitals, the role could be combined with the complex discharge planning role, but in most cases, it should be a separate role, she adds. "The job requires an experienced professional. A new nurse or social worker just exposed to acute care doesn't have the knowledge needed to be successful in the role," Cunningham adds.

The job of the transition case manager should be a stand-alone role and not combined with other duties, adds **Toni Cesta**, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts.

"Transition case managers shouldn't handle the day-to-day case management tasks, but should work with the unit case manager as a member of the team but have a distinct set of functions," she says.

Hospitals have to develop a detailed job description for the nurse navigator position and lay out specific tasks the navigator will or won't be doing, Cesta says.

"It's easy for the roles to blend. That why it's critical to have a detailed job description that identifies the responsibilities of the role and when the transition case manager gets involved," Cesta says.

Caseloads for transition case managers should be lower than those of the regular case managers so they'll have time to focus on the patient with complex needs, Rossi adds.

"Depending on the intensity or the complexity of the medical needs, some days the caseload might be 10 patients but on other occasions, the case load may be even lower," she says.

Rossi adds that transition case managers may need to work different hours from the traditional 8 a.m.-to-5 p.m. schedule many case managers follow. She suggests having the complex case manager work 11 a.m. to 7 p.m., or noon to 9 p.m. Monday through Friday.

"This will allow the case manager to have the flexibility to be available to work with families when they visit the patient after work," she says.

The concept of a transition case manager is still very new and it may take a while to sort out what the role will entail, Cesta says.

The details of the job may differ from hospital to hospital, but there is all one goal: ensuring that discharged patients have the services and support they need to avoid readmissions and/or ED visits, she adds.

The transition case manager in the hospital setting is typically a nurse who follows patients who are discharged to home with or without additional services by telephone for 30 to 90 days, Cesta says. The transition case manager doesn't necessarily follow patients going to a skilled nursing facility or a rehabilitation hospital, she says.

"The point is to make sure that patients who are discharged to home receive the services specified in the discharge plan, to answer any questions they have, and identify medical problems and take action before they escalate," she says.

In the beginning, the person in the new role and the existing case managers may bump into each other, Cesta says. To avoid duplication of services, educate the rest of the staff on the role of the transition case manager and their function on the team, she adds.

For instance, if a patient is still in the hospital, the regular case manager and social worker can never take a hands-off approach. They should collaborate with the transition case managers and stay involved with the patient, Cesta says.

The case management leadership should lead the effort to develop criteria for referring patients to the transition case managers. Depending on the hospital's patient population, patients could be identified by specific diagnoses, the number of hospital admissions, ED visits or readmissions, or amount of resources used, Cunningham suggests.

Create a dashboard so everyone is fully aware of what is going on. Include how many discharges the transition case manager handles each month, where the patients went, how many days they stayed in post-acute facilities, readmissions, and other outcomes metrics, Cunningham suggests. ■

Develop Criteria for Patients Referred to Complex Case Manager

Base it on assessments, not age or diagnosis

Don't base referrals to the complex case manager strictly on the age of the patient or the diagnosis, cautions **Peggy Rossi**, BSN, MPA, CCM, continuity of care service director for Kaiser Permanente Sacramento Medical Center, and consultant for the Center for Case Management.

"The case manager in this role must focus on patients with any complicating factor, whether it's medical, psychosocial, behavioral, poor compliance, or any combination of factors. These can affect patients of any age," Rossi says.

She recommends developing an in-depth assessment that captures the patient's current and previous level of illness and injury and functional ability. Include areas such as polypharmacy issues, psychological or mental health issues such as depression, the potential for falls, psychosocial and economic needs including a poor social support system, and potential caregiver burnout. Include questions on use of resources before admission, the patient and family's perception of the illness or injury, the home environment, and the ability of the patient and family to afford the copay for any care or services the patient will need. She suggests an initial assessment and reassessment as the hospital stay progresses.

"The complex case manager should use the information gleaned during the assessment and reassessment to develop discharge Plan A and discharge Plan B in case Plan A doesn't work. In some cases, Plan C may be needed," she says.

When the patient is ready for discharge, it's imperative for the complex case manager to ensure the patient has follow-up appointments, transportation to those appointments, and that information on the hospital stay is shared with the post-acute medical treatment team. The providers at the next level of care should have a copy of the discharge summary, and the case manager should communicate any key issues to the receiving clinician. ■

Communication is the Key to Ensuring a Successful Transition

Share information, ideas within and outside the hospital

"Communicate, communicate, communicate," should be the mantra of all case managers, says **Jean Maslan**, BSN, MHA, ACM, CCM, senior managing consultant for Berkeley Research Group, with headquarters in Emeryville, CA.

In the hospital setting, this means the inpatient case managers should communicate amongst themselves, with the patient and family, and the nurse navigator, who, in turn, communicates with patients and everybody involved with them after discharge.

"That is the hurdle that inpatient case managers need to overcome. The nurse navigator is the communication link between the hospital and the community. Inpatient case managers need to understand the importance of the role and work closely with the navigator," she says.

Maslan envisions the transition case manager or nurse navigator as part of the case management department, and who will collaborate with physicians, the rest of the team, and the community to provide support for patients when needed.

Communication with the inpatient case managers and participating in multidisciplinary meetings is crucial, she adds. "Nurse navigators have to be part of the whole inpatient care team so they understand everything that is going on with the patient. Inpatient case managers can look to the nurse navigator as an expert in community resources that could help patients after discharge," she says.

While they work side-by-side with inpatient case managers to develop the plan of care, the nurse navigators should be building a relationship with the patient and family, Maslan says.

"We want patients to call the nurse navigator when they are back in the community and having problems. The nurse navigator may be the person to stop patients from going back to the emergency department by connecting them with the right services in the community, which for many patients starts with the physician's office," she says.

The biggest gaps in care occur as patients transition from the hospital and back into the community, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts. "Communication between case managers across the continuum to coordinate care for patients at highest risk is essential," she adds.

It's always helpful if someone performs an assessment in the patient's home to discover any problems the patients are having or issues that weren't uncovered during the hospital stay, says **Sharonne L. Lynch**, LMSW, CCM, former director of social work at ArchCare at Terence Cardinal Cooke Health Care Center in New York City.

"When patients are in the hospital setting, the nurses, doctors, and other clinicians are taking care of them. When the patient is home, it's a whole new ball game. They have all those bottles of new medication, pages of discharge instructions, and it can be overwhelming. When a nurse or social worker visits the homes, they can see the conditions and patient support system firsthand and correct any problems," she says.

Nurse navigators are the key to improving post-discharge communication and helping patients stay healthy in the community, Maslan says. "The nurse navigators have to go out in the community and visit patients in their homes to see their living situation firsthand. They may need to attend physician visits with the patient so they can explain the treatment plan," she says.

An important duty for transition case managers is to make sure the patient is linked to an appropriate care provider and that the provider has the information needed to pick up care of the patient without gaps, says **Beverly Cunningham**, RN, MS, consultant and partner at Oklahoma-based Case Management Concepts.

For instance, in the case of complex patients being discharged to home, the transition case manager should communicate with the case manager in the patient's medical home.

Other examples of the transition case manager's outreach include making periodic calls to a skilled facility to check up on patients covered under the bundled payment program for hip fractures, checking with a cardiac rehab provider to find out how myocardial infarction patients are tolerating rehab, and intervening with patients who haven't been participating in the program.

Community-based case managers, who may be nurses, social workers,

or trained lay workers, can be a good resource for some patients transitioning to the community, Cesta points out. The community case managers could be in a medical home, a physician office, a federally qualified health center, or be part of an accountable care organization, she says.

They can provide valuable help in working with the transition case manager to help patients move from the hospital to home and then assist them in navigating through the healthcare continuum, Cesta adds. Not every patient qualifies for community case management. It depends on the patient's source of funding or lack of funding, Cesta points out.

Case managers at the patient's insurance company can also help with transitions, Lynch says.

"A lot of insurance companies are now starting to see the effect of patients falling through the cracks and they are assigning care managers to follow them after discharge," Lynch adds.

She recommends that case managers who are coordinating post-discharge needs for patients collaborate with the insurance companies to share information and avoid duplication of services.

"The insurance company case manager is the one person who stays with the patients, whether they are in the hospital, a rehab facility, or a skilled nursing facility. Patients may have different case managers and social workers as they move through the continuum, but in most cases they continue to have the same insurance case manager," she says. ■

Home Visits Help Reduce Readmissions for At-risk Medicare Patients

Multidisciplinary team follow patient for 30 days

A program that includes post-discharge home visits for at-risk Medicare patients has resulted in significant reductions in readmissions for the more than 2,000 patients enrolled in Hallmark Healthcare's Community-based Care Transitions Program instituted by CMS.

A key to the success of the program was creating a new position for transition facilitators — lay staff who visit the patients in their homes within three days of discharge and follow up by telephone for 30 days, says **Cheryl Warren**, MS, RN, CMAC, chief clinical integration officer for Hallmark Healthcare, a network of community hospitals and health centers in the Boston area.

The goal of the program is to reduce readmissions and costs of care by improving the transition of patients from the inpatient setting, Warren says.

EXECUTIVE SUMMARY

Hallmark Healthcare's Community-based Care Transitions project created the position for transition facilitators who visit at-risk patients in their homes and achieved significant decreases in readmissions.

- Transition facilitators work as a team with inpatient case managers, a nurse practitioner, and a pharmacist.
- They see at-risk patients in the hospital, visit them in their homes within three days of discharge, set up any community services needed, and follow them by telephone for 30 days.
- The nurse practitioner and pharmacist make home visits to patients who need extra assistance in following their treatment plan or medication regimen.

The health system has seven transition facilitators who have undergone six weeks of intensive training. The transition facilitators are not licensed staff, but most have a background in social work, case management, or a related healthcare field, Warren says. "They are supporting patients and coordinating services rather than handling clinical needs," Warren says.

They work as a team with the inpatient case managers, a nurse practitioner dedicated to the program, and a pharmacist to oversee transitions from the inpatient setting to home or a skilled nursing facility, she says.

Some transition facilitators work full-time; others part-time. They make rounds in the hospital in the morning and see patients in their homes in the afternoon.

In preparation for beginning the Community-based Care Transitions Program in December 2013, the Hallmark case management team

conducted a root-cause analysis to determine why patients were being readmitted. The team determined patients with diseases such as heart failure, chronic obstructive pulmonary disease, and pneumonia were at highest risk and designed the program to target at-risk Medicare beneficiaries.

The inpatient case managers refer patients who are at risk to the transition coordinators, who rotate taking new referrals. Often, the patients live alone with little or no support system, rely on an assistive device for mobility, and have deficits in activities of daily living. "Most often, they need meal deliveries, help with obtaining or paying for medication, transportation to appointments, or housekeeping assistance," Warren says.

The transition facilitator meets the patient while he or she is in the hospital, and explains the program. The facilitator conducts an assessment to determine the patient's support at home, establishes a baseline level of function, and determines what services the patient will need after discharge. "They begin to establish a relationship with the patients and compile an inventory of what they anticipate the patient will need. Then they arrange for the services when the patient is about to be discharged, and visit the patients after discharge," she says.

The transition facilitator makes follow-up phone calls for 30 days and hands the patient off to the primary care provider's office, or the ambulatory case manager.

The nurse practitioner conducts rounds with the transition facilitators and evaluates patients enrolled in the program. He or she identifies the patients who would benefit from a nurse practitioner visit in the home, such as patients with frequent admissions, those on multiple medications, or those who need extra education about their treatment plans. In the home, the nurse practitioner checks vital signs, goes over the clinical teaching, and collaborates with the patient's primary care provider and adjusts medications or changes treatment plans when necessary.

The pharmacist conducts a chart review on 100% of the patients in the hospital and determines who may need special teaching on diet and medication, who are taking multiple medications and are adding more prescriptions, and others who might benefit from a pharmacy visit a home. If the patient is taking a large number of medications, the pharmacist visits the home and reviews all the medicines, and educates the patients on which to take and when.

THE HOME VISITS ALLOW THE TEAM TO IDENTIFY PROBLEMS THAT COULD LEAD TO A READMISSION AND TAKE ACTION BEFORE THE PATIENT GETS WORSE.

"Everybody enrolled in the program gets a visit from the transition facilitator. The team decides on a case-by-case basis if a visit from the nurse practitioner or pharmacist is needed," Warren says.

The home visits allow the team to identify problems that could lead to a readmission and take action before the patient gets worse, and spot social needs that the patient didn't reveal during the assessment, Warren says. The transition coordinator makes sure the utilities are working, that there is food in the kitchen, and conducts a safety check. In some cases, the facilitator arranges more community services to meet the patient's needs.

"The transition coordinators find out things in the home that we never would know otherwise. Sometimes patients have the same medication they were prescribed in the kitchen cabinet or the medicine cabinet and are taking both," she says. That's when the transition facilitator calls in the pharmacist. If the patient is showing signs and symptoms that indicate his or her condition is getting worse, the facilitator calls the nurse practitioner.

The transition facilitator alerts the patient's primary care provider about the hospital stay and checks with durable medical equipment providers, home health agencies, and other organizations to be sure the equipment or services are in place.

Most patients get just one visit from the transition facilitator, but occasionally, the facilitator feels the patient could benefit from a second visit, Warren says.

The transition facilitator and a nurse practitioner oversee patient care for 30 days. They make sure patients have follow-up appointments and transportation, have filled their prescriptions, are following their discharge instructions, and have any equipment they need. For example, the discharge instructions may call for patients to weight themselves daily, but they don't have a scale.

In some cases, the team visits patients who are transferred to a skilled nursing facility. "The team participates in care coordination and discharge planning activities in the facility, and makes home visits and follows up when the patient is discharged," she says. ■

Respite Care for Homeless After Discharge Cuts Avoidable Days, Readmissions

Hospitals, social organization collaborate on post-discharge care

Hospitals in Santa Rosa, CA, saved $17 million dollars in first three years after investing $800,000 in Catholic Charities' Nightingale program that provides a place for homeless patients to recuperate after being discharged from the hospital.

The program targets patients who no longer meet inpatient criteria, but who are too frail and sick to be released to the streets and need extensive bed rest during a recovery period. In the past, the patients would have stayed in the hospital for weeks at a time or been discharged back to the street and ended up back in the ED, says **Jennielynn Holmes**, MPA, director of shelter and housing for the Catholic Charities of the Diocese of Santa Rosa.

The savings were calculated by multiplying the daily cost of hospitalization by the number of days patients would have been likely to stay in the hospital if they couldn't go to the respite shelter, Holmes says.

Located in a federally qualified health center, the program houses the patients in a unit similar to a hospital ward. The program provides a safe environment where patients can have bedrest while they recuperate, she says.

Patients receive medication and medical care from the adjacent clinic. They receive three meals a day and have access to a TV room. The program also provides comprehensive case management for patient. A case manager helps connect patients with housing resources and other community benefits that can help them after they leave the shelter.

"We are not a medical program. The staff provides caregiving services, but the patients have to be able to provide most of their own care. We do remind them to follow their medication regimen. Most patients are not accustomed to a regular routine and they need reminders to take their medication," Holmes says.

The program started in late 2011 with 13 beds for patients with low acuity. It expanded last year with another 13 beds for people with higher needs. Patients who need specialized care, such as wound care, receive it from home health staff. An adjacent clinic takes care of other medical needs.

Kaiser Permanente, Santa Rosa Memorial Hospital, and Sutter Medical Center funded the initial 13-bed program and continue to provide funding. Sonoma County began providing funds when the program expanded.

"Sonoma County was so impressed with the initial result that the Board of Supervisors agreed to provide funds when we wanted to expand to take patients with higher needs," Holmes says.

When case managers at the participating hospitals identify a patient who is homeless, they contact the Nightingale program. Nightingale's intake coordinator visits the patients in the hospital, assesses them for eligibility, explains the program, and begins to develop a relationship with the patients. "We have to be very careful about who we take because we don't have the staff to care for patients with complex needs," Holmes says.

After discharge, patients are transported to the shelter by taxi. Patients stay at the Nightingale shelter an average of 30 to 45 days. One patient who was terminally ill stayed for eight months. "We assess people regularly and as they become stronger and more mobile, we transfer them to another shelter,"

EXECUTIVE SUMMARY

An $800,000 investment in a respite program that provides a place for homeless patients to recuperate after discharge has saved participating hospitals in Santa Rosa, CA, $17 million in the first three years.

- Qualified patients get a bed in a ward in a federally qualified health center and three meals a day. The health center provides medical care and case managers who connect patients to community resources.
- Hospital case managers identify patients who no longer meet inpatient criteria but are too sick to be released to the street, and contact the program's intake coordinator to visit patients and enroll them in the program.
- Representatives from the three hospitals and Catholic Charities, which administers the program, meet quarterly to discuss ways to work together.

she says.

The three major hospitals in the community were part of Nightingale from day one and helped develop the program, Holmes says. "They knew the community really needed the services and they were happy to participate," she says.

Holmes visits each hospital quarterly and talks to the staff about what is working and what needs to be improved. "It's a great opportunity to do troubleshooting and to collaborate on solutions for problems," she says. Participants at the meetings include discharge planners, the head of social work, representatives from the quality department, and the person in charge of funding. "I want to find out how the program is working from both a clinical and a funding perspective," she says.

Data from the Nightingale project is being included in an initiative by the University of Notre Dame and Catholic Charities USA to find the best practices in poverty reduction.

Holmes hopes the program can be replicated in other communities.

"We partner with the medical community to get these patients everything they need for a successful recovery. They treat the patients' medical problems while we coordinate their social needs. We have achieved a great return on investment and are providing a service to the people who need it most," Holmes says. ■

Technology is Great, but Use it With Caution

Protect your patients' confidentiality

Today's technology can be a valuable tool that helps case managers perform the myriad tasks they have to complete in a day. But using technology can leave case managers wide open for ethical breaches and violations of HIPAA, warns **Ellen Fink-Samnick**, MSW, ACSW, LCSW, CCM, CRP, director of social work education for Athena Forum.

"Case managers have to manage a steady flow of patient information throughout their work day. They use technology for discharge planning, insurance review, quality outcomes, Medicare, Medicaid and other insurance regulations, and other activities. But when they use technology, they need to take steps to preserve patient confidentiality," she adds.

For instance, a case manager calls a patient's family and accesses the patient record on the computer. While waiting for the family to return the call, the case manager goes to a meeting with another family, leaving the patient's protected health information on the screen.

"This scenario and other privacy breaches happen because case managers have to do things quickly and they don't have time to think. But they still have to be careful that patient information is protected," Fink-Samnick warns.

Start ensuring patient confidentiality by making sure the department's records are available only on a need-to-know basis, Fink-Samnick recommends.

"People will snoop. If someone who is famous ends up in the hospital, it's tempting for staff to access the records either out of curiosity or, in some cases, to sell the information to a media outlet," she says.

She explains the case of a small hospital system that treated a group of local teenagers who overdosed on drugs or alcohol during a party. "People who were not involved with treating the patients started looking at the charts, at first just for patient status, then for more details. A lot of people were fired," she says.

Frequent communication with patients and family members is essential, but communication through unsecured devices may not be the best practice from a legal and ethical standpoint, Fink-Samnick says.

"Just because it's easier for patients and family members, it's not necessarily the best practice for case managers. Healthcare data breaches that yielded protected healthcare information about patient and families started in 2009. More than 90 million people were impacted by a single episode," she adds.

Case managers need to be sure the devices they use to contact patients and families after hours are secured and cannot be hacked, she says.

For instance, case managers should not send text messages to patients and families unless the hospital has provided a cell phone that enables secure texting.

Hospitals should have a comprehensive policy and procedure for sending protected information by email and the case management staff should be thoroughly trained on how to comply, adds **Elizabeth Hogue**, Esq, a Washington, DC-based attorney specializing in healthcare issues.

Case managers should take extra care when they transmit protected health information, whether it's to patients or to other providers, Hogue

says. First, she advises, consider alternatives to the disclosure of protected health information in email. Make a phone call or send the information on a CD, DVD, or flash drive by an overnight delivery service. Or, use encryption to protect the information you email. Encryption programs must meet the standards published by the National Institute of Standards and Technology, she points out.

"Case managers and discharge planners may find encryption very cumbersome. You have to remember to encrypt your message if your hospital's information system doesn't encrypt automatically. Then, patients or providers have to have a password to open the message," she points out.

However, the Office of Civil Rights ruled that if a patient emails you, you can conclude they have consented to email communication and reply without encrypting your message, Hogue says.

When case managers take their work home, they need to make sure the device they use to download patient information is secure and HIPAA compliant, Fink-Samnick says.

Social media presents a different, but equally important, set of potential HIPAA and ethical breaches, Fink-Samnick says.

Fink-Samnick advises case managers not to become friends on Facebook with patients and families, no matter how close the relationship becomes.

Clinicians know they shouldn't talk about patients in public areas. The same is true about social media, says **Patrice Sminkey**, RN, chief executive officer for the Commission for Case Management Certification.

Be careful what you post on social media, as it can come back to haunt you, she says.

"Case managers should remember that anyone can do a search and find out what they have posted if they don't have the highest privacy settings," she says.

Can posting a photo or comment on social media get you fired? Absolutely. An Internet search will turn up dozens of cases of nurses and other clinicians losing their jobs over something they posted on Facebook, Instagram, and other social media outlets.

Sminkey tells of a clinician who posted a selfie taken in a patient's room on social media. When the photo was enlarged, a small part of a monitor containing patient information was revealed. The clinician was fired.

"The selfie included an unintended snapshot of the patient's electronic medical record. This was a simple error in judgment that ended up getting the clinician fired," she adds.

When a celebrity is a patient, starstruck staff may be tempted to post it on social media, Sminkey says. "It may be fun or exciting to reveal that you've seen the celebrity, but what seems like fun could be devastating to your career," she warns. ■

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CE QUESTIONS

1. What is the date that CMS set for the launch of the proposed Bundled Payments for Cardiac Care Initiative?

A. January 1, 2017
B. July 1, 2017
C. October 1, 2017
D. January 1, 2018

2. How long does the transition facilitator at Hallmark Healthcare follow at-risk patients after discharge from the hospital?

A. 30 days.
B. 60 days.
C. 90 days.
D. As long as needed.

3. What is the average length of stay for patients in the Nightingale program for homeless patients who need a place to recuperate after hospitalization?

A. Two weeks.
B. 60 to 90 days.
C. Eight months.
D. 30 to 45 days.

4. Posting a comment or photo containing protected health information on the Internet or social media could get you fired.

A. True
B. False

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