HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Case Managers Are Aging, But Who Will Take Their Place?

Responsibilities are increasing — but staff is not

As payers shift their emphasis to quality of care and tighten reimbursement, case managers are becoming more essential than ever before to hospitals' survival.

Case managers now have a much bigger role in healthcare organizations, says **Vivian Campagna**, RN-BC, MSN, CCM, chief industry relations officer for the Commission for Case Manager Certification (CCMC). "Hospitals are looking for lower costs and better value, and case managers are playing a big role in achieving that," she says.

> "IN RESPONSE TO PAYER REGULATIONS, HOSPITALS ARE ADDING MORE RESPONSIBILITIES TO THE CASE MANAGEMENT ROLE BUT AREN'T ADDING ANY MORE FULL-TIME EQUIVALENTS."

While the need for case managers in the hospital is increasing, the case management workforce is aging and older case managers are leaving the profession, Campagna says.

She points out that 10,000 baby boomers are retiring every day, and case managers are among them. Some seasoned case managers who are reaching retirement age are looking for jobs that don't require them to work full-time, she adds.

The median age range was 55-59 for the largest group of board-certified case managers responding to Health2 Resources and CCMC's January 2017 Professional and Demographic Characteristics of CCMs survey, Campagna reports.

"In response to payer regulations,

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hospitals are adding more responsibilities to the case management role but aren't adding any more FTEs [full-time equivalents]. This is adding to the increase in burnout for many case managers," says **Mindy Owen**, RN, CRRN, CCM, principal owner of Phoenix Healthcare Associates in Coral Springs, FL, and senior consultant for the Center for Case Management.

Some case managers are leaving the profession because they feel the department isn't supported by the C-suite leadership, Owen says.

"They are told they have to add certain tasks to their daily workload, but they feel there is a lack of understanding and support as to what impact it has on the overall role case management plays. Job satisfaction isn't there and they're looking elsewhere in healthcare for a role that is less stressful and is seen as more supported," she adds. For instance, case managers may carry a caseload beyond realistic expectations for extended periods of time, and they may feel defeated and start burning out.

"Management doesn't understand the reality that their staff is burning out, the unrealistic expectations, and therefore is reluctant to make adjustments," she says. *(For tips on improving staff satisfaction, see related article on page 42.)*

Even with the emphasis on care coordination and recognition of the value of case management, case managers are still being asked to do more with less, says **BK Kizziar**, RN-BC, CCM, owner of BK & Associates case management consulting firm in Southlake, TX.

"When we talk to clients, we're finding more and more that the role of case manager is critical. But because case management is such a vital role, in many hospitals case managers focus on many components of the episode of care and become the jack of all trades and the master of none," adds **Tina Wiseman**, MEd, chief administrative officer of Novia Solutions.

"To be effective in today's healthcare world, case managers have to become familiar with all the details of the cases and nuances of the patient's situation in order to determine how patients need to progress. They have to focus on the hospital stay, transition to the next level of care, and even after that,"

EXECUTIVE SUMMARY

Hospital case managers are being asked to take on a bigger, more important role — but, in many cases, staff is not increasing, leading to high caseloads, low morale, and burnout.

- Case management leadership must be cognizant of what their staff faces daily and make the case to hospital management for hiring more full-time employees in the department.
- Analyze your needs before recruiting, be aware of the characteristics needed to fill the spot, and involve front-line staff in the hiring process.
- Create a robust orientation, training, and mentoring program to prepare new case managers for their own caseload.
- To improve staff satisfaction, recognize case managers' achievements, celebrate Case Management Week, and hold retention interviews to gauge staff's likes and dislikes.

Kizziar says. But in many cases, they simply don't have the time to do so, she adds.

If case managers partner with the treating physicians to ensure that patient needs are met during and after discharge, it can have a huge effect on length of stay and reimbursement, Kizziar adds.

But, too often, case managers either don't have the opportunity to communicate with physicians except by sticky note, which can be ineffective, or physicians are not open to communication, she says.

Case management departments are more successful when they are supported by a strong physician advisor program inside the department, Owen adds. For example, there are occasions when case managers know patients are ready to be discharged but the attending physicians may not be willing to complete their part of this process for a variety of reasons.

"If the physician advisors are not willing to intervene in a timely manner with their peers about the transitions of care, case managers feel frustrated and unsupported," she says. On the other hand, when physician advisors are a collaborative arm for both the case managers and their peers, the process is more successful, she adds.

Part of the problem is that many case management departments suffer from a lack of strong leadership and a commitment to what case management should be and how it is practiced, says **Catherine M. Mullahy**, RN, BSN, CCRN, CCM, president and founder of Mullahy and Associates, a case management training, education, and consulting firm in Huntington, NY.

Mullahy reports that she and her team frequently hear from case managers who are concerned that their leaders are not knowledgeable about the essential activities that case managers should perform, and are not familiar with the Case Management Society of America's standards of practice.

"These case managers share that most of their time is spent on phones or at their computers, so they have minimal time to actually have conversations with their patients," she adds. Many also complain of large caseloads and report feeling overwhelmed, frustrated, and disheartened, she adds.

"IF THE PHYSICIAN ADVISORS ARE NOT WILLING TO INTERVENE IN A TIMELY MANNER WITH THEIR PEERS ABOUT THE TRANSITIONS OF CARE, CASE MANAGERS FEEL FRUSTRATED AND UNSUPPORTED."

In some cases, the hospital administration is directing the department to concentrate on matters other than care coordination, such as compliance issues, documentation, and other regulatory matters, she adds.

"When we have leaders who are more influenced by hospital administration than adhering to the principles of good case management, it's no wonder why there are staff shortages and staff burnout," she says.

Case management leaders must be passionate and committed to the practice of case management, Mullahy says.

"This should be evident in their ability to strongly represent and communicate to senior management the role of case managers, their goals, their concerns, and the quality, safety, and overall experience of care the patients are receiving," she says.

Case management leadership should be aware of daily staff issues and should stay informed about all of the changes occurring in healthcare, Campagna says. "A lot of new rules and regulations that affect case managers are coming down the pike. It's really important for case management directors to stay on top of what is happening so they can determine how the case management process in their departments needs to change to meet these requirements," she adds.

Case management directors must be aware of payer requirements from a compliance and risk management perspective as well as from a revenue perspective, Owen says. "If the case management director is not on the top of his or her game and doesn't understand all the complexities and impact the regulations can have on an organization, the hospital is likely to lose revenue and encounter risk management issues," Owen adds.

She points out that Medicare audits can have a huge effect on hospitals if case management leadership is not on top of the regulations. "Compliance with payer rules and requirements weren't as impactful years ago as they are today, but in today's world it is the case management department that is looked to for understanding, guidance, and collaboration with risk management and quality to maintain compliance for the facility or health system," Owen says.

It's up to case management leadership to make sure the hospital administration understands how healthcare and reimbursement are changing and how the changes affect case management, Campagna says. They must show hospital leaders how case management affects quality and safety, she says. "Educate management that CMS is looking at how well hospitals provide case management service and how positive their outcomes are," she adds. *(For more on how to justify adding staff, see related article below.)*

Case management director roles are vacant or have a high turnover rate and there aren't a lot of candidates with the experience and expertise needed, Owen says.

"There's not an abundance of experience out there to take on the director role. There's a huge group of case managers who are considering retiring, but there hasn't been a lot of mentoring to prepare younger case managers for management positions," she says.

One problem is a lack of understanding on the part of the hospital's senior management about what is needed to be a successful case management leader, Owen adds.

"A lot of organizations go back to the theory of 'a nurse is a nurse is a nurse' when they fill case management leadership positions. But the head nurse on a nursing unit isn't prepared to transition easily into being a case management director," Owen says.

She points out that the case management process requires a specialized skill set that bedside nurses don't necessarily possess. Case management directors also must be knowledgeable about regulatory requirements from Medicare and contractual obligations from third-party payers, and none of this is a focus in nursing programs today, she adds.

There is a trend in academia toward post-baccalaureate and master's programs for case managers, Campagna says. "It's similar to the training for an advanced practice nurse. Case management is beginning to become more of an advanced practice, and people are recognizing that," she says.

Campagna urges case management directors and experienced case managers to nurture and mentor young case managers to help them develop the skills needed for successful outcomes for their patients.

CCMC has seen an increase in the number of younger people, particularly millennials, who are becoming certified, she adds.

"Part of CCMC's goal is to encourage younger nurses and social workers and get them interested and excited about case management," Campagna adds. ■

It Takes Data to Convince the C-suite to Add Staff

Work with finance to get the figures you need

In many hospitals, senior management does not understand the importance of the case management role until the hospital is audited and penalties are assessed, says **Mindy Owen**, RN, CRRN, CCM, principal owner of Phoenix Healthcare Associates in Coral Springs, FL, and senior consultant for the Center for Case Management.

"Senior management becomes engaged because the hospital is taking a financial hit. That's when it's time to make the case for the tools, department structure, and an alignment of FTEs [full-time equivalents]," she adds.

To justify adding staff, case management leaders must speak a language that the C-suite understands, and that is finance, adds **BK Kizziar**, RN-BC, CCM, owner of BK & Associates case management consulting firm in Southlake, TX.

"Management may appreciate anecdotal accounts or subjective information, but it's not going to convince them to spend money," she says.

Case management directors must show solid clinical data to educate hospital leadership on the role of case management, what case managers contribute to the bottom line, and what the department needs to function effectively, says **Vivian Campagna**, RN-BC, MSN, CCM, chief industry relations officer for the Commission for Case Manager Certification.

"When making the case for additional staff, the case management director needs to acknowledge what the investment of the hospital will be — but also show the return on investment. Management has to understand that increased staff and lower caseloads mean that case managers can do better management of the acute care episode and transition plan, which helps to

prevent readmissions and helps the hospital avoid readmission penalties," she says.

There's no magic number for determining the ideal caseloads. "It depends on the job description and the case management model," Owen says.

"It's hard to pinpoint a benchmark for caseloads. It depends on the acuity of patients, whether or not they have insurance, and other factors. It may take an entire day to plan one discharge, while other discharges can be handled in a shorter period of time," Campagna adds.

There's a fine line between the financial and the clinical aspects of healthcare, and case management directors must be on top of both, Kizziar points out. Case management directors need data to demonstrate the savings and avoided costs because of case management interventions, she adds. "It's critical to convert what case managers do to dollars," Kizziar says.

Work with the hospital's financial team to obtain the data needed to demonstrate how much case management interventions can save, Kizziar suggests.

"Financial staff may not necessarily be able to provide the cost for a service, but they can provide the charge for the services delivered. If this is the case, case management leadership should ask for the cost-to-charge ratio and use that to come up with financial data," Kizziar says.

For instance, if a service is charged at $100 and the cost-to-charge ratio is $20, you know the service cost the hospital approximately $80, she says.

Look through the charts for duplicate services, such as daily chest X-rays on pneumonia patients or repeated tests. Add up the costs and point out that case management interventions could have prevented the duplication.

Track the number of patients who stayed in the hospital longer than needed and multiply the number of excess days by the cost per day. At the same time, tabulate the days that were saved by case management interventions, and multiply that by the cost per day.

In your presentation, include examples of when a case management intervention could have saved money, Kizziar adds. An example might be a case where three specialists were consulting on a patient and the attending physician wouldn't discharge the patient until the specialists approved, so the patient stayed an extra day.

"The case management director can tell hospital leadership that the problem could have been avoided if the case manager had been coordinating care for the patient and making sure the consultants act in a timely manner. Then, add that the case managers can't coordinate care very well if they have a huge caseload," Kizziar says.

Compare the rate the hospital receives for reimbursement to the cost of care to determine if the hospital can meet patient needs and successfully transition patients at a reimbursement rate that helps maintain operations, Kizziar says.

"Hospitals can charge whatever they want, but it's what they get paid that counts," Kizziar says. ■

Know What to Look for Before Hiring New Staff

Analyze the team's needs

One of the biggest challenges case management directors face is balancing the need to fill the vacancy quickly with the importance of hiring the right person, says **Tina Wiseman**, MEd, chief administrative officer of Novia Solutions. "Leadership shouldn't drag their feet, but they shouldn't make snap decisions," she says.

Before starting the hiring process, case management leadership should look at the current staff's characteristics and list the skills the ideal candidate should have, Wiseman says.

"This activity helps you understand the dynamics of your team and what a good candidate for the position would be. That helps you to find an applicant who will fit in," she says.

Recruiting case managers in today's world must be very strategic, Wiseman says. "The candidate has to align with key hospital goals and has to be an individual who is malleable and who can work with external as well as internal colleagues," she says.

Case management leaders must understand all the critical factors that make case managers successful in their particular hospital. "You want a good fit, but you also want someone who will stay," she says.

Examine the current case management team and the interdisciplinary team and how they work.

Is the team collaborative, or do the members work as individuals? Then, choose a candidate who will fit into the dynamics of the team, Wiseman suggests.

Start the recruiting process by looking at the model the case management department is using, says **Mindy Owen**, RN, CRRN, CCM, principal owner of Phoenix Healthcare Associates in Coral Springs, FL, and senior consultant for the Center for Case Management.

"You have to have a good understanding of what the model is before you can look for what characteristics the person you hire should have," she adds.

Questions to consider when hiring a case manager include the following:

- Is the case manager responsible for utilization management as well as discharge planning and care coordination?
- Are social workers part of the department?
- Is there a strong case management assistant program?
- Is a physician advisor team embedded in the department?

"One of the critical things to consider is the type of clinical background the person should have. Can a nurse with experience in the intensive care unit adjust to coordinating care for other types of patients, or do you need someone with a general background for this particular job?" Wiseman says.

Other questions to think about include:

- Do you need a nurse or a social worker?
- How should the new person fit into the overall dynamics of the department and the organization?

Consider the types of patients you serve, Wiseman suggests. For instance, a safety net hospital may need case managers with a different type of background from those who will fit in a hospital that treats few unfunded patients.

"It's important to dissect your patient population to determine the critical clinical background needed," she says.

Don't turn the entire recruiting and hiring process over to the human resources department, warns **Catherine M. Mullahy**, RN, BSN, CCRN, CCM, president and founder of Mullahy and Associates in Huntington, NY.

Case management directors and managers must be involved in the recruitment process, she says. At the very least, the department leadership should create a profile of the ideal case manager and share it with the human resources staff so appropriate candidates can be selected, she says.

"It is essential for the human resources staff to understand the requirements, responsibilities, past experience, and education that the case management department looks for in good candidates," Mullahy says. ■

Get Input From Staff About Team Member Candidates

Develop a list of open-ended questions

The most effective way to choose a new employee who will fit in with the current team is to give the team a chance to interview the candidates and provide input, says **Mindy Owen**, RN, CRRN, CCM, principal owner of Phoenix Healthcare Associates in Coral Springs, FL, and senior consultant for the Center for Case Management.

"The people who will be the new case manager's peers should be part of the hiring process. After all, they're the ones who will work with and mentor the new person every day," she says.

In her more than 20 years as a case management director, **Peggy Rossi**, BSN, MPA, CCM, ACMC-RN, CMAC, an independent case management consultant based in California, found it to be most effective when a two-person team interviewed the patients.

"It was usually me and a supervisor or manager. We used a predeveloped list of questions and alternated asking them. I always told the candidate in advance that we would be taking notes," she says.

Following the interview with case management leadership, Rossi arranges for two to three peers to interview the candidates and report to her. "It's critical for the staff who will work with the new person to have a chance to meet and evaluate them. After we got their feedback, the manager and I compared our

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CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

Compliance Measures for the Case Manager's Daily Practice — Part 2

Toni Cesta, PhD, RN, FAAN

Introduction

Last month, we reviewed the Medicare Conditions of Participation for Utilization Review and how they affect the role of the case manager. This month, we will discuss the Conditions of Participation for Discharge Planning.

To be compliant in the role of utilization manager, one must understand what the term "medical necessity" means. When talking to a physician or patient about care that may not be medically necessary, be clear as to what this means and ensure that the hospital receives reimbursement and that the patient is being cared for in the most appropriate setting. The definition of "medical necessity," according to the American College of Medical Quality, is as follows:

"Medical necessity is defined as accepted healthcare services and supplies provided by healthcare entities, appropriate to the evaluation and treatment of a disease, condition, illness, or injury and consistent with the applicable standard of care."

TO BE COMPLIANT IN THE ROLE OF UTILIZATION MANAGER, ONE MUST UNDERSTAND WHAT THE TERM "MEDICAL NECESSITY" MEANS.

To best understand this definition, we will review the seven components of medical necessity. The overarching message is that a patient should receive neither more nor less than what they require at a specific point in time.

Seven Components of Medical Necessity

1. Determinations of medical necessity must adhere to the standard of care that applies to direct care and treatment of the patient.

2. "Medical necessity" is the standard terminology that all healthcare professionals and entities will use in the review process when determining if medical care is appropriate and essential.

3. Determinations of medical necessity must reflect the efficient and cost-effective application of patient care, including, but not limited to, diagnostic testing, therapies (including activity restrictions, aftercare instructions, and prescriptions), disability ratings, rehabilitating an illness, injury, disease, or its associated symptoms, impairments or functional limitations, procedures, psychiatric care, levels of hospital care, extended care, long-term care, hospice care, and home healthcare.

4. Determinations of medical necessity made in a concurrent review should, when possible, include discussions with the attending provider as to the patient's current medical condition.

- A physician advisor/reviewer can make a positive determination regarding medical necessity without necessarily speaking to the treating provider if the provider has enough available information to make an appropriate medical decision.
- A physician advisor cannot decide to deny care as not medically necessary without speaking to the treating provider. These discussions must be clearly documented.

5. Determinations of medical necessity must be unrelated to the payer's monetary benefit.

6. Determinations of medical necessity must always be made on a case-by-case basis consistent with the applicable standard of care and must be available for peer review.

7. Recommendations approving medical necessity may be made by a non-physician reviewer.

• Negative determinations for the initial review regarding medical necessity must be made by a physician advisor who has the clinical training to review the particular clinical problem (clinically matched).

• A physician reviewer or advisor must not delegate his or her review decisions to a non-physician reviewer.

8. The process for evaluating medical necessity should be explained to the patient.

9. All medical review organizations shall have uniform, written procedures for appeals of negative determination that services or supplies are not medically necessary.

It is clear that these components apply to the role of the RN case manager as well as the physician advisor, and should be taken into account when conducting a clinical review or when a physician advisor is reviewing a case.

Hospital-Issued Notice of Noncoverage

Hospital-Issued Notices of Noncoverage, or HINNs, are documents that hospitals may issue to Medicare fee-for-service patients if the hospital intends to hold a patient financially responsible for all, or part, of a bill. The hospital is not required to issue a HINN.

Carefully consider issuing HINNs, as these can result in a negative relationship between patient/families and the hospital staff. Potential problems can be avoided through discussions with patients and families. This is why it is best to have an RN case manager deliver the HINN rather than a clerical person or someone in the patient access department.

When Is a HINN Issued?

The HINN is issued if the care the patient is, or may be, receiving is not covered under the Medicare fee-for-service program. Services may not be covered for any of the following reasons:

• the service is not medically necessary;

A HINN IS A DOCUMENT THAT HOSPITALS MAY ISSUE TO MEDICARE FEE-FOR-SERVICE PATIENTS IF THE HOSPITAL INTENDS TO HOLD A PATIENT FINANCIALLY RESPONSIBLE FOR ALL, OR PART, OF A BILL.

• the service in not being delivered in the most appropriate setting;

• the care is custodial in nature.

Before issuing a HINN, the case manager should contact the physician of record for any additional information related to the patient's case that may change the decision to deliver the HINN. If the patient cannot understand the HINN, his or her representative can receive the document. A HINN may not be issued where the Emergency Medical Treatment and Active Labor Act (EMTALA) applies, such as in the ED. All patient billing must meet CMS billing requirements, although this is not a responsibility of the case manager.

If for any reason the HINN is issued incorrectly, the patient cannot be held financially responsible. Be sure to include the physician advisor any time that the attending physician does not support issuing the HINN.

HINN vs. ABN

The other type of notice that you may be required to give is an Advance Beneficiary Notice of Noncoverage (ABN). The difference between the HINN and the ABN is that the ABN is given when outpatient services are not covered. This may include ambulatory diagnostics or procedures that are being denied or may be denied. The HINN is used for inpatient services only.

Types of HINNs

The following are the four types of HINNs:

1. The first is the pre-admission/admission HINN. This HINN is issued when the physician has ordered inpatient care that would usually be covered under Medicare, but the care is determined to not be medically necessary or the level of care being ordered is not appropriate to the patient's clinical condition.

For example, a pre-admission HINN might be issued when the admission does not meet national or local coverage determinations and would result in nonpayment from Medicare. Another example is if, after review, the case does not meet the level of care ordered.

2. The second type is the HINN

10, or the Notice of Hospital Requested Review. This is used when the hospital determines that the patient no longer needs inpatient care, but the attending physician does not agree. In this case, the hospital would request that the quality improvement organization (QIO) review the case and determine whether the patient still needs inpatient care.

3. The third type is the HINN 11. This is issued when a diagnostic or therapeutic service that is not medically necessary is ordered during an otherwise covered inpatient stay. It may only be used when the published Medicare coverage policy confirms that the item or service is not medically necessary.

An example of when the HINN 11 might apply would be when a patient who is undergoing medically necessary bowel surgery asks the surgeon to also perform a tummy-tuck at the same time. In this case, the tummy-tuck would not be a covered service and the HINN would be delivered to the patient while the QIO reviews the case.

4. The fourth type is the HINN 12, which applies when the patient initially met an inpatient level of care, but the hospital, with the concurrence of the physician or the QIO, determines that the patient no longer needs inpatient care and the physician plans to discharge the patient. In this case, the HINN would be delivered while the QIO reviews the record.

The HINN 12 is the most commonly used of the four types of HINNs. It is issued when a patient is ready to be discharged to a lower level of care such as subacute or skilled care, but the patient and/or family refuses to cooperate with the discharge decision.

Part of the Patient's Financial Experience

Because utilization management and compliance are so intertwined, they can affect the patient's financial picture during current or future hospitalization. Therefore, it is critical that the patient and/or his or her representative are kept in the loop regarding any payer-related issues or concerns. Examples of these areas include the following:

- The Important Message from Medicare;
- Advance Beneficiary Notice;
- HINN;
- Benefits — reimbursement for non-covered services;
- Medicare Outpatient Observation Notice (MOON);
- patient choice list;
- discharge limitations related to payer issues.

We will discuss these areas in a future issue covering compliance. For now, we will turn our attention to the Conditions of Participation for Discharge Planning, the other critically important Condition of Participation most greatly affecting case management.

Conditions of Participation for Discharge Planning

The Conditions of Participation (CoP) for Discharge Planning (Section §482.43) focus on the process of care coordination for discharge and transitional planning. According to these regulations, hospitals are expected to do the following:

- Create a discharge planning process applicable to all patients. The related policies and procedures must be made available in writing.
- Identify the patients in need of discharge planning and post-discharge services at an early stage of hospitalization.
- Provide a timely discharge planning evaluation for patients who require it and for those who request it, regardless of need.
- Have a licensed professional, such as an RN, social worker, or other appropriately qualified professional develop or supervise the development of the discharge planning evaluation.
- Include a timely evaluation of the patient's likelihood of needing post-hospital services, and arrange for the services before discharge to avoid unnecessary delay.
- Evaluate the patient's capacity for self-care or the possibility of returning to the pre-hospital environment.
- Document the patient's discharge plan in the medical record.
- Share the discharge plan with the patient or designee for approval and counseling.
- Assess the patient's discharge needs on an ongoing basis while hospitalized, revise the plan when necessary, and prevent discharge delays.
- Refer or transfer the patient to other facilities and providers as needed for follow-up care and share the necessary information.

Expanded Discharge Planning Rules

In November 2015, CMS published proposed changes to the discharge planning rules. The following is a list of the proposed changes and their potential effect on case management:

- **Patients discharged from critical access hospitals, long-term acute care hospitals, inpatient rehab hospitals, observation**

service, EDs, and ambulatory surgery, as well as patients receiving procedures that require sedation or anesthesia, will require a discharge plan before leaving the hospital. This change would necessitate adding case management to these areas, and/or expand the role of the staff nurse.

• The discharge plan will be required to start within 24 hours of admission. Case management departments will need to staff adequately to perform discharge planning assessment promptly.

• Post-acute quality measures should be provided to patients. CMS recommends that these measures come from its star ratings. It is also required that hospitals document in the medical record that the list was presented to the patient or an individual acting on the patient's behalf.

The star ratings can be found on the Nursing Home Compare and Home Health Compare websites.

• Patient information should be shared with next level of care providers.

It is recommended that this information is shared both verbally and electronically.

• The practitioner responsible for the patient's care must be involved in the discharge planning process and participate in the documentation of the plan.

It is not always common for the physician to document the discharge plan in the medical record, so this expectation may require physician education and a standardized documentation template.

• Patients discharged home should have a copy of their discharge summary sent to their community-based physician within 48 hours of discharge.

Pending lab results should be sent within 24 hours of discharge. This process should be an automatic interphase when possible.

• The discharge planning process must be written and approved by the hospital board (both initially and routinely).

The discharge planning process can be approved when the utilization review plan in approved and should take place annually.

CASE MANAGEMENT DEPARTMENTS SHOULD CONSIDER ADDING A FAMILY CAREGIVER ASSESSMENT TO THE ADMISSION ASSESSMENT WHEN A FAMILY CAREGIVER IS INVOLVED.

• Patient or family caregiver capability and availability must be considered.

Case management departments should consider adding a family caregiver assessment to the admission assessment when a family caregiver is involved.

• Availability and access to non-healthcare services must be considered.

This includes home and physical environment modifications, assistive technologies, transportation services, meal services, household services, and housing for homeless patients. Case managers should be sure to document this information in the medical record.

• The discharge plan must address the patient's goals of care and treatment preferences and document these in the medical record.

Case management documentation must be comprehensive enough to include this information.

• The discharge planning process must be reassessed on a regular basis.

The process should be reviewed by case management leadership via a sample of discharge plans each month.

Staffing Patterns

The expanded rules most likely will require that your department reassess its staffing patterns, including:

• days of the week that require full staff support rather than a minimal staff (skeleton);

• hours of staff coverage;

• changes in volume of staff that will be needed to cover additional clinical areas such as ambulatory procedures, ambulatory surgery, observation, and the ED.

In addition, you will need to address IT solutions that may be needed for transfer of data to post-acute providers and other settings, as well as discharge planning summaries and diagnostic test results.

Summary

This month, we completed our discussion of utilization review compliance and began our review of compliance with the conditions of participation for discharge planning. We will continue our compliance series next month with more on the discharge planning CoPs and review the other areas of compliance required by case managers and case management departments. ■

(continued from page 34)
ideas with the staff's and made a decision about who would fit," she says.

"A group approach to hiring works well," says **Tina Wiseman**, MEd, chief administrative officer of Novia Solutions. "Ultimately, the director makes the decision but it's more holistic if the peers and leadership the candidate will be working with have an opportunity to talk with the candidates and share their impressions with the director," she says.

Wiseman recommends that a panel of three peers interview candidates and share their perceptions with the director. She suggests setting an hour aside for the interview and giving each staff member time to ask questions.

Develop three to five open-ended questions designed to give you an idea of the candidate's personality and soft skill set, Wiseman says.

"There are some clinicians who are highly skilled and do an excellent job caring for patients from a technical standpoint, but they don't have the empathy to be a good case manager," she says.

The Novia team developed a tool that helps case management leadership assess the kind of characteristics that make a successful case manager. The tool includes specific questions that give employers an understanding of how a potential employee would act in certain situations.

For instance, the person conducting the interview might ask candidates to describe a time when they disagreed with a decision, how they handled it, and what happened, Wiseman says. Another question might ask the candidate to tell about encountering a negative attitude on the part of a fellow staff member, a patient, or a family member and give details on how he or she handled it.

Another way to probe for "soft skills" is to describe a situation that happened in the hospital, take out any details that might identify the participants, and ask the candidates how they would handle it.

"CASE MANAGEMENT IS WHERE THE RUBBER MEETS THE ROAD. CASE MANAGERS FOCUS ON THE BUSINESS ASPECTS OF CARE, AND IT'S TOTALLY DIFFERENT FROM NURSING. NURSES HAVE TO BE ABLE TO TAKE OFF THEIR NURSING HAT AND PUT ON THEIR CASE MANAGEMENT HAT."

Wiseman's suggestions include a situation when the case manager must explain to family members that a patient will not function the same way after a stroke, or how to address the care team and physicians to identify and overcome the barriers that are preventing the discharge of a patient who no longer meets inpatient criteria.

"If you set up real-life examples and the candidate has to give you a story about how they will deal with the situation, you will get a sense of what they are like, whether they are going to be confrontational, or take a partnership approach," she says.

Watch candidates' body language when you interview them, Rossi says. "Watch their hands and feet. If they are uncomfortable, they will start squirming," she says.

Wiseman and her team developed a set of questions for candidates, including how they might deal with a difficult physician, how they approach death and dying, or whether they are willing to make hard decisions about discharge. She'd ask the candidate to describe an example of a patient or family who was difficult to deal with and how he or she handled the situation.

"Just make sure you ask everyone you interview the same question," she says. "I looked for the certified case managers. Certification means they've gone the extra mile and know what they are doing."

When she interviewed nurses who were interested in becoming case managers, one of the first questions Rossi asked was, "Can you give up hands-on nursing care and handle the case management job?"

A significant number of nurses are moving into case management with no background in case management and no understanding of the process, Rossi says.

"Case management is where the rubber meets the road. Case managers focus on the business aspects of care, and it's totally different from nursing. Nurses have to be able to take off their nursing hat and put on their case management hat," she says. ■

What Makes a Good Case Manager? Look Beyond the Résumé

Compassion and caring are essential traits

The skills that make a good case manager are not necessarily those you find on a résumé, points out **Vivian Campagna**, RN-BC, MSN, CCM, chief industry relations officer for the Commission for Case Manager Certification.

"A candidate's education and experience are important, but it's the personality and character that make a case manager successful," she adds.

Look for people with a passion for giving, nurturing, and caring for people, Campagna adds. For instance, a good case manager must be able to relay tough information compassionately, she says. "When those hard messages have to be delivered, it's important that the person who delivers them can do so in a gentle and caring way," she says.

"A seasoned case management director will get a sense of whether the person they are interviewing has the personality and the passion for the role," Campagna adds.

Look for people who are clinically mature and have the skill set to be successful in case management, says **Mindy Owen**, RN, CRRN,CCM, principal owner of Phoenix Healthcare Associates in Coral Springs, FL, and senior consultant for the Center for Case Management.

"A good case manager should be comfortable with technology, but also comfortable at the bedside. They need to have good negotiation and collaboration skills as well as being able to work independently," she says.

Choose a candidate who has a real interest in patient advocacy and who is flexible and creative, Campagna says. "Effective case managers question the status quo and recognize that just because it's always been done a certain way, it may not be the right way in a particular situation. They challenge themselves to find different ways of doing things within the expectation of what the outcome should be," she says.

Many hospitals are continuing to hire case managers who are generalists into the department, but there may be a need for a specific, specialist role, Campagna says. She recommends looking for someone who can learn the basic concepts of the specialist job as well as understanding the case management process.

"If they have the skills to be a case manager, they can be trained for the specialty. Likewise, if someone has experience in a particular specialty, they will need to learn the case management process," she says.

But don't think that just anyone who is experienced in the healthcare field will make a good case manager, says **Catherine M. Mullahy**, RN, BSN, CCRN, CCM, president and founder of Mullahy and Associates in Huntington, NY.

"Leadership at many organizations mistakenly believe that hiring experienced nurses and social workers automatically will ensure competency in case management. The knowledge and skills they have acquired over the years are certainly helpful and transferrable. However, there are additional and specific skills and knowledge that are necessary to have a staff of competent and confident case managers," Mullahy says.

When vacancies occur, **BK Kizziar**, RN-BC, CCM, recommends giving any healthcare professional who is interested in the job the opportunity to learn case management.

For example, nurses who have experience in managed care or Medicare know the basics of the healthcare business and have the ability to see both sides of the issue. "The advantage of these nurses is that they don't come to the position with the idea that paying attention to financial issues is not good for clinical care," says Kizziar, owner of BK & Associates in Southlake, TX.

Owen suggests that applicants who have not been case managers or have experience in a different venue have the opportunity to shadow a case manager for a day before they come for an interview. This gives the applicant a sense of how the case management process works and how things are done in that particular organization. "After they shadow a case manager for a day, some people realize that the position is not for them. It's good to find out an applicant isn't comfortable with the case management process before you hire them," she says.

It takes a mix of certified and non-certified case managers to build a successful department, Owen says. The certified case managers should be mentors to the newer case managers and help them work on achieving certification.

"I believe every case manager should strive for certification, but it's idealistic to think the whole department will be certified," she says. ■

There's No Such Thing as an Instantly Prepared Case Manager

Create a robust training program for new hires

It often take six months to a year for a new case manager to feel comfortable in the role, says **Catherine M. Mullahy**, RN, BSN, CCRN, CCM, president and founder of Mullahy and Associates in Huntington, NY.

That's why case management departments must develop a formal training and educational program for new hires, mentoring by other staff in the department, and provide ongoing support, Mullahy says.

Training time varies depending on the experience and background of the new case manager, says **Mindy Owen**, RN, CRRN, CCM, principal owner of Phoenix Healthcare Associates in Coral Springs, FL, and senior consultant for the Center for Case Management.

"If someone has no case management experience, training is a minimum six-month process. If utilization management is part of the job, it could take as long as nine months or more to get new case managers ready to work on their own," Owen says. If the new hire has case management experience, he or she may be ready to take on a caseload sooner, she says. "Training is an investment, both on the side of the case management and of the organization," she adds.

Training for new case managers should include instruction on the role of case managers and not just the tasks they perform, adds **Vivian Campagna**, RN-BC, MSN, CCM, chief industry relations officer for the Commission for Case Manager Certification.

"They need to understand the big picture and how to manage an episode of care across the continuum," she says.

Someone who is new to case management needs a formal orientation that lasts a minimum of eight weeks, Campagna says. As the formal orientation progresses, assess the person to determine if he or she can take on a caseload or if more support is needed, she says.

Campagna recommends pairing new hires with a preceptor before they work alone. "The preceptor gets a sense of how the new case manager functions, what they learned, and where they may need reinforcement," she says.

No matter what kind of experience a new case manager has, says **Peggy Rossi**, BSN, MPA, CCM, ACMC-RN, CMAC, a minimum of four weeks of orientation is desirable. "They have to feel comfortable within the organization," she says. "Ideally, orientation takes six to eight weeks, followed by time with a preceptor," she says.

During orientation, Rossi recommends that the new case managers meet with case management leadership and staff members, and then spend time with the chief financial officer and heads of major departments.

"After orientation, the new case managers should spend half a day with the clerical staff to get a feel for the dynamics of the unit, and then shadow a case manager for a day. Then, the preceptor should assign them one of two cases and observe them to see if they need more training," she says.

Before new case managers take on a caseload, rotate them through the surgery department, the ED, and ICU to make sure they get a good feel for the hospital, Rossi adds.

Nurses who have been on the floor must learn case management, says **BK Kizziar**, RN-BC, CCM, owner of BK & Associates. But rather than starting with true case management, assign them to perform utilization management tasks so they can learn what payers are looking for, what documentation is required, and the importance of coordinating with physicians, she says.

She recommends setting up a formal preceptor program with a comprehensive list of tasks new case managers must perform for their preceptor, and a clinical ladder that assesses ability, performance, and certification for the entire case management staff.

Encourage your staff to get involved with professional organizations and to attend conferences, Kizziar suggests.

Provide regularly scheduled educational sessions to keep the staff up to date on the latest payer regulations, community resources, and other information they need.

Case management departments must use a dedicated educator to ensure training is consistent for new hires. "When the training is done by staff, the new staff learn to do things the way their trainer does them and it's not always the right way," Rossi says.

In addition to training staff, the educator should keep the staff informed about policies and

procedures and changing demands from payers, and keep the case management department's orientation manual current so case managers will have an up-to-date reference source, she says. ■

Increase Job Satisfaction by Making Staff Feel Appreciated

Recognize their successes, ask them for suggestions

Retaining experienced staff should be a focus of every case management department, says **Tina Wiseman**, MEd, chief administrative officer of Novia Solutions. "When people leave, you lose a lot of knowledge," Wiseman says.

The secret to keeping experienced staff on the job is to make them feel appreciated and give them the tools they need to be successful, according to long-time case managers.

A truly successful case manager doesn't see the position as a job. They see it as a passion, and the reward is more than just a paycheck — it's his or her successes, says **BK Kizziar**, RN-BC, CCM, owner of BK & Associates.

"Case managers' job satisfaction is based on recognition of their successes as well as their salary, and when the staff feels satisfied there's little attrition. It's important for the case management department and the hospital to recognize the contributions of case managers — as a department and as individuals," she says.

She recommends that administrators round with case managers periodically to understand the role and to acknowledge the contribution of case management. "When the administration views case management as an important role that contributes to the success of the institution, it makes case managers feel appreciated," she says.

The key to retaining staff is to be fair and consistent and make sure that case managers receive up-to-date education on anything that affects their jobs, says **Peggy Rossi**, BSN, MPA, CCM, ACMC-RN, CMAC. "They need to know about new resources in the community and new regulations from CMS when they are issued — and not six months later," she adds.

"WHEN THE ADMINISTRATION VIEWS CASE MANAGEMENT AS AN IMPORTANT ROLE THAT CONTRIBUTES TO THE SUCCESS OF THE INSTITUTION, IT MAKES CASE MANAGERS FEEL APPRECIATED."

Listen to what staff is saying and act on it, Rossi says. "This way, they realize you're looking out for them and they will have faith in you," she adds.

Recognize case management successes in meetings, Kizziar says, and celebrate National Case Management Week on Oct. 8. "Very few hospitals recognize Case Management Week at the same level as weeks honoring nurses, but it's important to recognize the value of case management on a hospitalwide basis," Kizziar says.

If you want to know what case managers like and don't like about their job, retention interviews are one way to find out, Wiseman points out.

"People value being able to give feedback. It gives them a sense of organizational trust when management wants to know what they could do better," she says.

"A lot of places conduct exit interviews, but when people are leaving, it's too late. Having a conversation with current staff is a good way to understand what is working and what it not working," she adds.

Wiseman recommends one-on-one interviews to find out what staff members like and don't like about their jobs. "They're more effective than focus groups. People are more willing to open up as individuals than in a group setting," she says.

If you or your staff are uncomfortable discussing problems directly, create a short survey online and ask the staff to take it anonymously. "This creates a sense of objectivity because participants aren't speaking to someone who is their direct manager," she says.

Pull together all the results from the interviews or surveys and look for trends, Wiseman suggests.

Retention interviews have a two-fold advantage, Wiseman says. "They help case management leaders understand what is working and what isn't working, and make changes to keep people on the job. It also gives you information to leverage during the hiring process," she says. ■

CMS Announces Voluntary Bundled Payment Program

Continuing its move toward basing reimbursement on quality, the Centers for Medicare & Medicaid Services (CMS) announced a new voluntary bundled payment model that starts Oct. 1 and ties payment to participants' performance on quality measures.

The Bundled Payments for Care Improvement Advanced program "builds on the earlier success of bundled payment models and is an important step in the move away from fee-for-service and toward paying for value. Under this model, providers will have an incentive to deliver efficient, high-quality care," says CMS administrator **Seema Verma**.

The move came just weeks after CMS canceled the mandatory hip fracture and cardiac bundled payment programs, which were scheduled to begin on Jan. 1, 2018, and continue through Dec. 31, 2023.

The new program includes 29 inpatient clinical episodes and three outpatient clinical episodes. The episode of care begins at the start of an inpatient or the start of an outpatient procedure and ends 90 days later. Participants will receive regular Medicare fee-for-service payments for care.

The program will evaluate providers' performance retrospectively every six months, comparing the total cost of care for the clinical episode to a target price that will be provided before the performance period begins. Payment for participants also is tied to performance on quality measures. CMS will use the performance and quality data to determine whether the provider will receive a bonus or is required to repay CMS for part of the reimbursement.

CMS has designated seven quality measures that will be used in the program. The all-cause hospital readmission measure and advance care plan measure will be required for all clinical episodes. The other five will apply only to select clinical episodes. They are perioperative care; selection of prophylactic antibiotic; first- or second-generation cephalosporin; hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty; hospital 30-day, all-cause, risk-standardized mortality rate following coronary artery bypass graft surgery; excess days in acute care after hospitalization for acute myocardial infarction; and AHRQ Patient Safety Quality Indicators.

The 29 inpatient clinical episodes are the following:

- acute myocardial infarction;
- back and neck, except spinal fusion;
- cardiac arrhythmia;
- cardiac defibrillator;
- cardiac valve;
- cellulitis;
- cervical spinal fusion;
- chronic obstructive pulmonary disorder, bronchitis, and asthma;
- combined anterior/posterior spinal fusion;
- congestive heart failure;
- coronary artery bypass graft;
- disorders of the liver, excluding malignancy, cirrhosis, and alcoholic hepatitis;
- double joint replacement of the lower extremity;
- fractures of the femur and hip or pelvis;
- gastrointestinal hemorrhage;
- gastrointestinal obstruction;
- hip and femur procedures except major joint;
- lower extremity/humerus procedure except hip, foot, femur;
- major bowel procedure;
- major joint replacement of lower extremity;
- major joint replacement of upper extremity;
- pacemaker;
- percutaneous coronary intervention;
- renal failure;
- sepsis;
- simple pneumonia and respiratory infections;
- spinal fusion (non-cervical);
- stroke;
- urinary tract infection.

The three outpatient clinical episodes are:

- percutaneous coronary intervention;
- cardiac defibrillator;
- back and neck, except spinal fusion. ■

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. Log on to AHCMedia.com, then select My Account 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. **According to BK Kizziar, RN-BC, CCM, case management leaders can persuade hospital management to add new positions to the department by providing anecdotal accounts and subjective information.**

   a. True
   b. False

2. **Tina Wiseman, MEd, recommends asking a panel of peers to interview candidates for case management positions. How long does she think the interview should last?**

   a. One hour
   b. Half an hour to 45 minutes
   c. Depends on the situation
   d. As long as it takes

3. **According to Catherine M. Mullahy, RN, BSN, CCRN, CCM, how long does it take for new case managers to feel comfortable in the position?**

   a. Six weeks
   b. Three months
   c. Six months to a year
   d. A year or longer

4. **When will the Centers for Medicare and Medicaid Services' new Bundled Payments for Care Improvement Advanced program begin?**

   a. July 1, 2018
   b. Oct. 1, 2018
   c. Jan. 1, 2019
   d. Jan. 1, 2020

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.