HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

RELIAS MEDIA

MARCH 2019 Vol. 27, No. 3; p. 25-36

Healthcare Advocates Are Sounding Alarm About Immigration Rule Change

Proposed rule received more than 216,000 comments

Case managers and other healthcare providers say they noticed a trend in fall 2018 when legal immigrant Medicaid patients became concerned about visiting doctors and hospitals and using their coverage to receive preventive care.

Legal residents, refugees, and other immigrants who received Medicaid or similar services began to say they were afraid of continuing to access services. Their expressed anxiety was attributed to a proposed rule issued by the Department of Homeland Security (DHS).

> "ALMOST HALF OF THEM HAVE TOLD US THEY HAVE CLIENTS WHO ARE NERVOUS AND ARE DISCUSSING DISENROLLING FROM MEDICAID BENEFITS AND MEDICARE SAVINGS PROGRAMS."

The proposed rule, published Oct. 10, 2018, in the *Federal Register*, would add more factors for immigration officials to consider when determining whether a noncitizen is a "public charge" — an individual likely to be a long-term financial burden in the United States and therefore ineligible for a visa or permanent residency.

The new factors would include, among other things, whether the person receives or would receive certain government healthcare benefits, such as nonemergency Medicaid services. *(The proposed rule can be found at: http://bit.ly/2FqGM3R.)*

Financial Disclosure: Author **Melinda Young**, Editor **Jill Drachenberg**, Editor **Jesse Saffron**, Editorial Group Manager **Terrey L. Hatcher,** and Nurse Planner **Toni Cesta**, PhD, RN, FAAN, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

HOSPITAL CASE MANAGEMENT

Hospital Case Management™, ISSN 1087-0652, **is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *Hospital Case Management*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.**
GST Registration Number: R128870672.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
ReliasMediaSupport@relias.com
ReliasMedia.com
Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year (12 issues) with free Nursing Contact Hours or CMCC clock hours, $519. Add $19.99 for shipping & handling. Online only, single user: 1 year with free Nursing Contact Hours or CMCC clock hours, $469.

Outside U.S., add $30 per year, total prepaid in U.S. funds.

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at groups@reliasmedia.com or 866-213-0844.

Back issues: $78. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.

ACCREDITATION: Relias LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.5] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers. The course is approved for 1.5 CE contact hour(s).

The target audience for *Hospital Case Management*™ is hospital-based case managers.

This activity is valid 36 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

AUTHOR: Melinda Young
EDITOR: Jill Drachenberg
EDITOR: Jesse Saffron
EDITORIAL GROUP MANAGER: Terrey L. Hatcher
SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

EDITORIAL QUESTIONS
For questions or comments, call Jill Drachenberg at (404) 262-5508.

"We are hearing stories of concerned individuals asking questions and not understanding whether or not they should or should not access healthcare services in California hospitals," says **Carmela Coyle**, president and chief executive officer of the California Hospital Association in Sacramento.

Similar stories were coming out of other regions, as well.

"We have a large network of community-based organizations, and we sent out a survey in November. Almost half of them have told us they have clients who are nervous and are discussing disenrolling from Medicaid benefits and Medicare savings programs," says **Leslie Fried**, JD, senior director at the Center for Benefits Access at the National Council on Aging in Arlington, VA.

This was occurring even though the rule is not finalized. The U.S. Citizenship and Immigration Services (USCIS) of DHS collected 216,102 comments from citizens and organizations, including many from case managers and other healthcare providers. An extensive look at the comments would suggest that most are opposed to the public rule change.

The proposed change would replace the May 26, 1999, regulation on public charge, published by the former Immigration and Naturalization Service. Mark Phillips, chief of the residence and naturalization division of USCIS, did not respond to an email request for comment. The request was sent during the government shutdown when some DHS offices were closed.

"DHS seeks to better ensure that aliens subject to the public charge inadmissibility ground are self-sufficient, i.e., do not depend on public resources to meet their needs but rather rely on their own capabilities, as well as the resources of family members, sponsors, and private organizations," according to the proposed rule. *(See chief changes in proposed rule, page 28.)*

Among the more than 100 citizen comments supporting the proposed public charge rule are letters that express a desire to ensure immigrants do not receive government assistance. A few commenters wrote that they support "the public charge rule because new immigrants since our nation's earliest days have been required to demonstrate they are self-sufficient." *(Comments about the proposed rule can be read at: http://bit.ly/2QQvDdG.)*

Some healthcare organizations and case managers have expressed concern that the proposed rule goes too far — cutting off at-risk populations from the only health insurance they have, which could lead to these populations

EXECUTIVE SUMMARY

The Department of Homeland Security issued a proposed rule that would provide new factors for immigration officials to weigh when determining whether a noncitizen is a "public charge." A public charge is someone deemed likely to be a long-term financial burden in the U.S. and therefore ineligible for a visa or permanent residency.

- New factors for immigration officials to consider would include, among other things, whether the person receives or would receive certain government healthcare benefits, such as nonemergency Medicaid services.
- Since the proposed rule was issued on Oct. 10, 2018, some case managers have reported noticing a trend of legal residents and refugees considering refusing healthcare services out of fear of being denied permanent residency or citizenship.

becoming sicker and overcrowding EDs.

"Our greatest concern is the impact on people," Coyle says. "California is home to more than 10 million immigrants — we have more than any other state."

What the rule does is supersize the barrier to allowing legal immigrants to stay in the United States, she adds.

"We've already begun to hear reports of that chilling effect, of individuals concerned about using their Medi-Cal [California's Medicaid] for fear it will count against them on the big tote board of whether or not they can stay in the United States," Coyle explains. "The case management concern is about how do you manage the case of any individual when that person is afraid to use healthcare services, and that's what this proposed rule is doing."

Based on the California Hospital Association's recent analysis, 4.3 million Medi-Cal enrollees would forgo medical coverage if the proposed rule becomes a final rule, Coyle says.

"That's a disaster," she says. "One in three individuals in California is enrolled in Medi-Cal, so this is a very serious issue and, quite honestly, would create an enormous public health challenge."

More children and elderly people would die from avoidable causes, and EDs and hospital beds would be filled with people whose acute and serious illnesses could have been prevented through primary care and case management services, she adds.

"I think about the important work that our case managers do, using a toolbox full of tools to help patients return to health," Coyle says. "For immigrants, this proposed rule takes the toolbox, turns it upside-down, and empties it out."

The Affordable Care Act helped spread the benefits of case management and promoted preventive care and population health efforts. This measure could undermine those benefits for a significant number of people, one self-identified case manager wrote in a comment to immigration services in opposition to the proposed public charge changes.

"We cannot afford to go backward and make our population sick again. It just costs too much," wrote Debra Spence, a case manager for 18 years. She did not offer her professional affiliation.

"IF YOU HAVE A PATIENT WHO IS FEARFUL OF ACCESSING THAT CARE, IT CREATES AN ENORMOUS WALL BETWEEN THE CASE MANAGER AND THE INDIVIDUAL THEY ARE TRYING TO SERVE."

The change will directly affect case management, making care transitions challenging, Coyle says.

"It's the case manager's job to make sure someone accesses hospital services and has a clear pathway back into the community," Coyle explains. "But if you have a patient who is fearful of accessing that care, it creates an enormous wall between the case manager and the individual they are trying to serve."

Another potential effect would be infectious disease outbreaks among immigrant children who were not immunized out of fear of the public charge changes — or as a result of the changes, if the rule is finalized as proposed, she says. *(See suggestions for how case managers can educate affected patients, page 29.)*

The Children's Health Insurance Program (CHIP) makes preventive healthcare, including vaccines, affordable for low-income families, including immigrants. DHS is considering including CHIP in the list of benefits that would trigger a public charge finding because "the total federal expenditure for the program remains significant, and because it does provide for basic living needs (i.e., medical care), similar to Medicaid," the proposed rule states.[1]

One case manager wrote to DHS that if CHIP is included on the public charge list, it could prevent parents from vaccinating their children, forcing them to choose between their healthcare and green cards. This already is being felt, wrote **Lily Sonis**, LCSW, MPH, medical case manager, immigrant and refugee health program at Boston Medical Center.

"An immigrant mother I worked with was too afraid to sign her child up for CHIP because she was worried about how it might affect the child's ability to apply for permanent residency," Sonis writes. "The child needed vaccines to enter school, and the family had to pay out of pocket for the child's preventive care, which posed a significant burden to the family."

Sonis also notes that the proposed rule has a negative effect on refugees who would not be affected by the rule change.

"These populations are still often afraid to access services for which they are eligible," Sonis wrote. "One of our patients, who is seeking asylum on political grounds after being tortured and experiencing sexual violence, called me after the public charge proposed changes were announced to express her fear and confusion.

She was worried that she might be deported if she continues to receive health coverage through emergency Medicaid."

Emergency Medicaid is not on the public charge list, but this refugee patient could not be convinced that it was safe to continue her necessary medical and mental healthcare, she added.

Immigrant and refugee patients already are avoiding healthcare appointments and are not asking for help — a trend that could grow if the proposed rule becomes a final rule.

"Patients avoiding asking for help is antithetical to the foundation of my profession and will have disastrous consequences for our patients' health," Sonis wrote.

A care manager at a federally qualified health center in East Harlem, NY, submitted a comment about how the proposed rule would lead to severe health consequences for immigrant women and children, and is already having a deleterious impact.

"Recently, I sat with a pregnant woman in my office. She explained that she has difficulty putting food on the table for her and her two kids," wrote care manager **Belkyss Arias**. "I urged her to enroll in SNAP [Supplemental Nutrition Assistance Program] services given her eligibility, but she refused. She feared that her immigration status would be threatened," Arias continued.

"I pleaded with her to enroll, explaining that this was not the case, but she refused. I worry about the health of her two children without food and the health of her future child if she is not able to nourish herself throughout this pregnancy."

The proposal could lead to an increase in morbidity and mortality during delivery, longer NICU stays for infants, and an increase in preventable birth defects, Arias predicted.

Low-income immigrant families particularly would be harmed by the proposed changes, according to **Richard E. Besser**, MD, president and chief executive officer of the Robert Wood Johnson Foundation in Princeton, NJ.

"Children become a negative factor because they tend to be eligible for public benefits," Besser wrote in a comment to DHS.

An estimated 42% of noncitizens entering the U.S. without permanent residency status have characteristics that would be deemed "heavily weighted negative factors" and could trigger DHS to consider them public charges, Besser said.[2]

Besser's letter refers to a 2018 Kaiser Family Foundation study that also found that 94% of noncitizens who entered the U.S. without legal permanent resident status have "at least one characteristic that DHS could potentially weigh negatively in a public charge determination."[2]

According to Besser, "The proposed standard would reach all aspects of daily life, implicating millions of immigrants and their families — either directly or as a result of the rule's chilling effect — potentially leading to a wholesale withdrawal from public programs." ■

REFERENCES

1. Department of Homeland Security: Inadmissibility on Public Charge Grounds. *Fed Reg*. 83(196):51114-51296.
2. Artiga S, Garfield R, Damico A. Estimated impacts of the proposed public charge rule on immigrants and Medicaid. Kaiser Family Foundation, Oct. 11, 2018. Available at http://bit.ly/2M80txT.

Summary of the Proposed Public Charge Rule Change

It tackles Medicaid, SNAP, other benefits

In October 2018, the Department of Homeland Security (DHS) proposed adjusting the definition of "public charge," which is used to delineate noncitizens who are likely to pose a financial burden in the U.S. by relying heavily on government programs.

The definition is important because such individuals are ineligible for visas or lawful permanent residency.

For example, a person applying for a visa who is deemed a public charge might be turned down based on immigration officials' view that the person would not be able to support himself or herself while in the United States.

The current definition of public charge relates to a person who has been "committed to the care, custody, management, or support of the public," according to the proposed rule.[1]

DHS proposes a new definition, which it says clarifies the current one. A person would be considered a public charge if he or she takes "receipt of financial support from the

general public through government funding (i.e., public benefits)."

DHS defines those benefits to include the following programs, in which many legal immigrants are eligible to participate:

- Medicaid;
- Supplemental Nutrition Assistance Program (SNAP);
- Supplemental Security Income;
- Federal Rental Assistance;
- Low Income Subsidy for Medicare Part D Prescription Drug Coverage;
- Temporary Assistance for Needy Families (TANF), cash aid only;
- Children's Health Insurance Program (CHIP).

According to the proposed rule, "Food, shelter, and necessary medical treatment are basic necessities of life. A person who needs the public's assistance to provide for these basic necessities is not self-sufficient."

However, DHS makes clear that public charge determinations are based on a "totality of the circumstances." For example, DHS also would consider the individual's age (someone younger than 18 or older than 61 who is unemployed or has limited resources would be dinged); the individual's health status; whether the individual's assets and resources are less than 125% of the federal poverty level; and "household size in relation to [the] alien's household assets and resources."

Further, people who have not met vaccination requirements or who have chronic illnesses, mental disorders, addiction problems, or sexually transmitted diseases could be considered public charges. "An alien's financial status would also include the alien's liabilities as evidenced by the alien's credit report and score," the proposed rule says. ■

REFERENCE

1. Department of Homeland Security: Inadmissibility on Public Charge Grounds. *Fed Reg*. 83(196):51114-51296.

How Case Managers Can Assist Immigrant Patients

Case managers across the nation say they are encountering immigrant patients who fear receiving healthcare services through Medicaid, Medicare Part D Prescription Drug Coverage, and Children's Health Insurance Program (CHIP).

Their fears apparently arose from the Department of Homeland Security's (DHS's) proposed rule regarding "public charges," issued in October 2018. Those are noncitizens deemed by immigration officials to likely rely over the long run on government programs for basic needs; such individuals are ineligible for visas or permanent residency.

A key part of the proposed change would make receipt or potential receipt of certain government healthcare services, such as nonemergency Medicaid, a negative factor weighing against noncitizens, potentially threatening their visa or permanent residency status.

Case managers can help alleviate fears and ensure patients continue receiving needed services with the following:

• Know the proposed public charge rule and what it means.

First, case managers could explain that the proposed rule is not a law and is not in effect, and would not be retroactive if finalized. The benefits people receive today would not be used against them.

Also, it might take years for DHS officials to read through and address the more than 200,000 comments received about the proposal. Some proposed rules are never made final, and others can take more than 10 years to become final.

According to the U.S. Citizenship and Immigration Services, affected people would be "Individuals seeking immigrant or nonimmigrant visas abroad, individuals seeking admission to the United States on immigrant or nonimmigrant visas, and individuals seeking to adjust their status from within the United States. The proposed rule also would consider certain receipt of public benefits by individuals within the United States in a nonimmigrant (i.e., temporary) status who are seeking to either extend their stay or change their status."

However, case managers should not give patients a blanket statement that they would not be targeted. According to the proposed rule, while most lawful permanent residents are not subject to inadmissibility determinations, some can be subject to the public charge ground of inadmissibility. *(http://bit.ly/2Fxbbg9)*

"The rule should not impact people who have legal status, as it is written. We don't know what will happen, so our network is urging folks to talk to an immigration lawyer," says **Leslie Fried**, JD, senior director at the Center for Benefits Access at the National Council on Aging in Arlington, VA.

Keep advice simple when speaking with immigrant patients, Fried advises.

"Tell them the Department of Homeland Security would not look at benefits retroactively," she says. "Say you will inform them if the rule is finalized or if things change."

• Emphasize the importance of patients continuing to receive medical care.

"This is a proposed rule, and no one should change their patterns of care as a result of this government proposal," says **Carmela Coyle**, president and chief executive officer of the California Hospital Association in Sacramento.

"Make certain individuals who might be affected know that their hospital has their back and is on their side," Coyle says.

Case managers are educators, ideally suited to help patients understand that they are safe to receive healthcare services and that this proposed rule is a long way from being finalized.

"Case managers can alleviate concerns," Coyle notes. "They play an important role in this important moment." ■

Case Managers Can Help Patients, Physicians Understand Two-Midnight Rule

The Two-Midnight Rule has benefited hospitals in the past few years, but some facilities continue to have problems with implementing the rule.

The Centers for Medicare & Medicaid Services (CMS) finalized the rule in 2016 to provide a way for physicians to convert an observation patient into an inpatient. If the doctor expects the patient to stay through two midnights, then the patient can be admitted.

Some hospitals have struggled with receiving denials after recovery audit contractors (RACs) found problems with physician orders and documentation. This is a problem that hospital case managers can help resolve through better communication and education with patients and physicians.

Case management and utilization review are important to the process of following the rule's documentation and other requirements, says **J. Suzanne Wilson**, RN, MBA, ACM, assistant vice president of post-acute services/continuing care at AnMed Health in Anderson, SC. Wilson also is the chair of the national public policy committee of the American Case Management Association.

"The Two-Midnight Rule has been a journey for most health systems, along with a host of denials — RACs looking at every level of care. It isn't easy," Wilson says.

The Two-Midnight Rule change was intended to benefit patients financially, says **Linda Corley**, CPC, vice president of Xtend Healthcare in Nashville, TN.

CMS intended to fix a common problem in which patients were entering the hospital in outpatient observation for several days and doctors were unable to upgrade the patient to inpatient status due to existing clinical criteria, Corley explains.

"Outpatients are less acute; the medical conditions are not as complex as inpatient, so a person in the hospital as an outpatient owes a coinsurance amount for each day that the person is on outpatient observation," Corley says. "Outpatient observation patients also are charged individually for services they receive, like drug administration, imaging, diagnostic tests."

This results in patients who are in a hospital for four days as outpatients owing considerably more for their stay than a patient would have owed if part of that stay was inpatient, she adds.

Based on the Two-Midnight Rule, when a physician deems that an observation patient has been in the hospital for 24 hours and cannot be safely discharged, he or she can be upgraded to an inpatient stay, which Medicare would pay as if it were one entire inpatient stay.

As with most new rules, there are implementation pains. The Two-Midnight Rule is no exception, which is why CMS clarified the rule within a Medicare program final rule on the Hospital Inpatient Prospective Payment Systems for acute care hospitals in August 2018. *(http://bit.ly/2srxf43)*

During its first year, many hospitals received denials from Medicare. Often, the problem related to a documentation issue or technicality, Wilson says.

Some auditors would deny coverage even when the patient's acuity level met criteria for inpatient care. "If you didn't have that inpatient order, it was a technicality and you would not get paid," she says.

For example, a patient in observation for chest pain may go into cardiac arrest and die while in surgery. The physician who saw the

patient in the ED might not have written an inpatient order, and then the RAC denies that case, Wilson explains.

Clarification from CMS explained that cases like the example are not supposed to be denied because clearly the acuity is there for an inpatient stay, whether or not the order was written, she says.

Case managers are important to hospitals' strategies in staying compliant with the rule:

• Leverage tools. Case managers can use tools such as the electronic medical record (EMR) to help physicians document accurately and concisely. They also can check the EMR each day to ensure inpatients have the appropriate care order, Wilson says.

"We try to catch that concurrently," she says. "We look at reports and use reports and tools to help us with compliance."

For instance, case managers look at the wording of orders: "You place a patient in outpatient observation, so you don't use the word 'admit' for observation," Wilson explains. "You only use the word 'admit' for inpatient."

• Explain the Medicare Outpatient Observation Notice (MOON). Case managers make sure patients understand that they are in the hospital as an outpatient observation status, which is a Medicare-created term, Wilson says.

"These patients are less sick and have lower acuity, but we need more time with them than assessing them in the emergency room," she says. "A physician might choose observation status to better understand or evaluate the patient's illness, or maybe it's for a quick tune-up, administering medication or for fluid hydration."

Patients need to understand that their observation stay will be billed differently than if they were admitted to the hospital as an inpatient.

In CMS frequently asked questions, the agency makes suggestions for explaining the outpatient status to patients:

- "The physician has ordered outpatient observation services in order to evaluate your symptoms and diagnosis," and
- "Your condition and symptoms will continue to be evaluated to assess whether you will need to be admitted as an inpatient of the hospital or whether you may be transferred or discharged from the hospital." *(https://go.cms.gov/2VRAWgS)*

• Identify trends. Case managers can assist with identifying trends in how the Two-Midnight Rule is used.

For example, when the rule first was issued, hospitals' observation rates shot up nationally — an unintended consequence from CMS' perspective. This spike was partially due to RACs scrutinizing documentation and finding it falling short, Wilson says.

"It was, perhaps, an overuse of the observation status, and that was a national issue," she says. "At AnMed, our rate of observation was going down, but nationally it was a challenge for CMS."

Case managers can check for trends on the hospital level, specialty level, and even physician level by using their hospital-based reporting tools. Hospitals can find data about short stays through compliance tools, such as the Program for Evaluating Payment Patterns Electronic Report (PEPPER) that CMS provides, Wilson suggests. *(For more information, visit: https://pepper.cbrpepper.org/.)*

"The report helps us understand whether we're managing the Two-Midnight Rule in a compliant, appropriate way," she says. "We look at our observation rate, length of stay, and our PEPPER report for short stays."

There are seasonal fluctuations in the observation rate. In the winter months, it can be higher because of people in the hospital with flu or pneumonia. But if there is an unusual and sudden spike in the observation rate, then this suggests the need to dig deeper.

• Educate physicians and staff. "We educate staff and keep them updated on the Two-Midnight Rule, and we update them with *Federal Register* updates," Wilson says.

Case managers also educate physicians on patients' change in status, patterns, and trends.

"If we had a physician whose observation rate was 40%, we'd want to have a conversation to understand that," she says.

• Find alternatives to skilled nursing facilities (SNFs) as needed. One challenge with the Two-Midnight Rule is that if a patient has outpatient observation status of one day and inpatient for two days, there cannot be a transition to a SNF under Medicare rules. Patients must have a qualified three-day inpatient stay in order to access SNF benefits, and the time spent in observation does not count, per CMS guidance, Wilson explains.

This obstacle can be problematic in cases where the patient should be discharged but is not medically capable of being discharged home. Case managers can help in these situations by finding alternative discharge plans.

"The alternative might not be the patient's first choice, but we have to make sure we have the best discharge plan or optimal discharge plan for patients," Wilson says. "There are obstacles and barriers in that patient's funding source." ■

Stress Can Create Physical and Mental Health Problems for Case Managers

Stressors include paperwork, staffing shortages

Case managers and other professionals who experience stress might suffer job dissatisfaction, depression, sleep problems, headaches, upset stomachs, and other health issues, according to the CDC.

Burnout and moral distress can affect how case managers perform their jobs, as well as how they confront ethical dilemmas.[1] *(More information is available at: http://bit.ly/2RD7jk3.)*

Among the most common stress factors for case managers are redundant paperwork, competing deadlines, staffing shortages, and lack of resources, says **Dennis Fisher**, MM, who retired at the end of 2018 as the program director for the Behavioral Health Training & Education Network in Philadelphia.

"I've done stress management training for 10 to 15 years, and I've compiled a list of stressors for case managers and case management supervisors," Fisher says. *(Find more information at: http://bit.ly/2TxOSdZ.)*

Another stressor is working with populations experiencing serious physical or behavioral issues, he adds.

"There is the stress of not knowing what you're walking into," Fisher says. "This affects you physically, mentally, behaviorally — all the ways it plays out in life."

Hospital leaders can be alert to this type of stress and encourage case managers to ask for help whenever they feel overwhelmed.

"Have case managers negotiate a deadline or maybe give them the authority to do a report in a different way that might save time," Fisher suggests. "There's not a magic bullet to reduce stress, but there are some common things that, if you put them into practice and get permission to put them into practice, can be key."

There also are a number of proven stress reduction strategies that individual case managers can employ. Fisher suggests that overwhelmed case managers try these tactics:

• **Self-care.** "Get enough sleep — around seven hours a night. Get enough exercise, whether it's walking or something more strenuous," he says. "Try exercise that you can do three or four times a week for 20 to 30 minutes."

Also, case managers should take time to relax every day and watch what they eat, Fisher says.

"Early in my career, when I was doing case management and case management supervision, I ate a lot of doughnuts because it was something portable," Fisher says. "After I went to the doctor, who asked what I did for a living, I realized fruit was just as portable and better for me."

Music therapy also is a way to relieve stress, says Fisher, who started his career as a music therapist.

Another self-care strategy is to find activities that balance one's life. These might include a social network, religious faith, meditation, yoga, guided imagery, art, and listening to music.

"It helps to have a close friend or family member who you can vent to," he says. "Somewhere down the line, you could return the favor when you're less burned out than they are."

Everyone also benefits from giving and receiving love and affection. "That might be unconditional love of a pet."

• **Exercise.** People need exercise. It helps with stress, but it is a discipline that needs to be developed. By establishing a routine, someone could break through their desire to skip it and take that walk or run or bike ride.

"Schedule it. Block out times you can do it. Let other people be responsible for what they can be responsible for, so you can exercise," Fisher says.

"You can always justify taking time to exercise by telling [loved ones], 'I can give you better quality time if I'm less stressed out.'"

Exercise is part of that balance. A case manager who spends a portion of the day at a desk can balance out that time with 20 to 30 minutes of rigorous activity, he says. "If I'm sitting at a desk all day, I make sure I get physical activity."

• **Positive self-talk.** "Have a mantra you can say to yourself. It should be something you can remember and chant," Fisher says. "It should be something that brings you back when you are in the middle of a conflict situation."

Someone might choose to say or think, "Love, joy, peace, patients, kindness, goodness, faithfulness, gentleness, self-control," he says.

Positive self-talk is possible when someone is calm, so take deep breaths and make sure there's time for progressive relaxation, Fisher advises.

"Tense your muscles. Then do deep breathing, releasing the tension. Flex muscles and let go," he says. "Time breathing with it."

Most important, take five minutes

at the beginning of the day to walk around the building while engaging in positive self-talk.

"Don't look at your phone while you do this," Fisher says. ■

REFERENCE

1. Sortedahl C, Mottern N, Campagna V. Case managers on the front lines of ethical dilemmas: advocacy, autonomy, and preventing case manager burnout. *Prof Case Manag*. 2018;23(1):4-9.

Physical Therapy Can Be Alternative to Opioids

Case managers can look for drug-free pain relief options

For years, opioids for acute, chronic, and post-surgery pain were considered an affordable and effective pain management solution. That view ended once it became clear these medications were leading to rampant abuse and addiction, contributing to more than 47,600 overdose deaths in the United States in 2017.

"We know that opioids have been the go-to for chronic pain and acute pain for many years, and more recently, we're learning that opioids are not effective for chronic pain," says **Michelle Despres**, PT, CEAS II, vice president at One Call in Jacksonville, FL. One Call provides workers' compensation care management services.

"Opioids give brief relief early on, but they have no lasting effect," Despres says. "It doesn't help people, but they continue to follow that course and then get addicted and have all these other problems that continue to grow once they're addicted to opioids." *(More information is available at: http://bit.ly/2RNG0nf.)*

Brief treatment with opioids post-surgery and opioid treatment for cancer pain still work well, but clinicians increasingly are looking for alternatives for chronic pain. This is where physical therapy sessions can be of benefit, Despres says.

Before the late 1990s, when physicians began to prescribe opioids for noncancer pain more readily, doctors would treat back pain and chronic pain with acetaminophen, nonsteroidal anti-inflammatories, and recommend heat, ice, physical therapy, and self-massage, says **Marcos Iglesias**, MD, FAAFP, FACOEM, senior vice president and chief medical officer at Broadspire, a Crawford company and third-party administrator in Sunrise, FL.

Many physicians have used physical therapy as an alternative to medication in treating musculoskeletal pain, he notes.

"I'm a proponent of active methods of dealing with pain, and by that I mean something that engages the patient, as opposed to something done passively to the patient," Iglesias says.

The active approach includes exercise, physical, and social activities.

"Physical therapy, exercise, and returning to normal activities have the best long-term outcomes, and that's what we should be doing," Iglesias says. "It's a matter of what the evidence points to."

But it's not easy to convince patients to try these alternatives to opioids for their pain, and physicians are not always aware of nonmedication pain modalities. This is where case managers can help, Iglesias says.

"Case managers have a wonderful opportunity to influence both patients and physician drivers of opioid use," he says.

For example, when a hospital patient is prescribed opioids post-surgery or after a painful illness, the case manager can educate and explain the proper use and disposal of the drug: "If you take this medication home, make sure it's in a safe or locked place. Do you have children at home, or are there other people who will have access to your medication? How will you protect those people? What do you do with leftover medication? How do you dispose of it?" Iglesias says.

Case managers also can talk to patients about how they feel about shorter prescriptions of opioids and share patients' desires with physicians.

"You can tell the physician that the patient doesn't think there will be a need for more than two or three days of the medication," he says.

Case managers can ask doctors whether they'd be willing to prescribe the opioid for three days, then schedule a follow-up appointment to check on the patients' pain level, Iglesias explains.

"Physicians think they'd rather the patient didn't return to the hospital or emergency room because of pain, so they prescribe one to three weeks of opioids. But here's an opportunity to reduce the number of days the drug is prescribed and dispensed," he says.

Providers' attitudes about opioids have shifted over the decades, and the nation is in the middle of another big change.

"When I worked at an urgent care center in the 1990s, we had a lot of people coming in because of

pain and, usually, seeking an opioid," Iglesias says. "Before the doctor saw the patient, someone would have a conversation with them, saying, 'We're happy to see you for your pain, but please be advised that we don't use opioids.'"

When a patient decided to stay at the center for pain treatment, physicians would offer nonopioid treatments, he says. In those days, doctors were reluctant to prescribe opioids for noncancer pain. They worried about its addictive quality and the side effects, which include constipation, itching, and sexual dysfunction, Iglesias says.

"It's not that opioids just cause adverse effects, potential addiction, and overdose deaths," he explains. "But they're not that effective for some pain, including orthopedic and musculoskeletal pain, which does not improve as much as we thought compared with over-the-counter measures like ibuprofen and Tylenol."

These concerns began to fade after Purdue came out with OxyContin in the mid-1990s, and this drug was marketed as a safe treatment for noncancer and chronic pain. Societal views about pain began to shift toward thinking of pain as the fifth vital sign and that patients should be pain-free, he says.

"My colleagues started prescribing more opioids, higher doses, longer prescriptions, and even using methadone for musculoskeletal pain. And that's when I knew we were in deep trouble," Iglesias says.

"Methadone had only been used in helping individuals overcoming heroin addiction," he adds. "It's a strong medication with complex pharmacology, and it can cause adverse effects that other opioids don't cause — and now it was being used for low back pain."

Two decades later, and the medical community and society have shifted again. Opioids have proven devastating to many communities, with mortality rates that continue to rise. Physicians, insurers, and regulators have cracked down on opioid prescriptions, and nonopioid pain therapies are gaining more attention again, Iglesias says.

Look to Physical Therapy as Alternative

When people experience chronic pain, their bodies are out of balance. It might be that the initial acute pain from an injury has caused them to limit their movement, protecting their injury site. This causes pain to dig in, instead of to ease, Despres says.

"Once you get moving, sometimes that pain starts to feel better," Despres says.

Physical therapists help people achieve physical balance. "If something is too tight or too loose, if someone's joint is too mobile, physical therapists look to stabilize it, to balance it," she says. "If a person is out of shape, physical therapists work to help the person build up tolerance and strength."

The goal is to get patients moving and to help them change habits that are leading to pain. For example, if a worker experiences chronic pain due to their lifting mechanics, a physical therapist shows them how to lift properly, she adds.

Physical therapy also can help patients post-surgery, sometimes even replacing opioids for acute pain. For example, women who undergo a cesarean section delivery often are prescribed opioids despite these being problematic for nursing mothers. A physical therapist could help the recovering woman move, get out of bed, and recover mobility and strength.

"When I worked as a physical therapist in a hospital, we'd get people moving as quickly as possible," Despres says. "We'd get them to move all their limbs so things don't get stiff and they don't get blood clots."

What needs to happen more often in hospital and community settings is a conversation between patients and their case managers and physicians about what to expect with pain relief and why alternatives to opioids might work best in the long run, she explains.

"If a patient tries physical therapy first, there is no downside," Despres says. "Physical therapists can do things to help patients with pain. They have ultrasound, heat, all kinds of ways to give people relief right then."

When a physical therapist helps a patient get up, move around, and feel less pain due to motion and healing, they'll be more likely to continue to move and improve. "Then patients will think, 'These things work, and I can move and get out of here, and life will be fine,'" she explains. "This experience just reinforced the whole emotional side of their injury and that they can get relief."

But if patients start off with opioids and receive instant gratification, it's more difficult to get them to try alternatives, she notes.

Depres suggests physical therapy as an alternative to opioids for the following:

• **Cesarean section.** "A physical therapist can teach protection of the surgical site, teaching the patient the correct body mechanics to protect the incision," she says. "They teach the woman how to get out of bed, how to cradle her baby, and they educate on the importance of early movement — not lying in bed all day, but being active."

Physical therapists also can teach recovering mothers how to protect

their surgery site while returning to normal activity. They can teach leg exercises and low-level, graduated exercises, including range of motion and movement. They can teach light strengthening, body mechanics, and even how to care for the scar, Despres says.

• **Post-surgery pain.** Physical therapists can teach post-surgery patients body mechanics, how to transfer safely from the bed to the floor and bathroom, how to get in and out of a car, and how to go up and down a curb or step, she says.

"We teach post-surgery patients the things they need to protect themselves so they don't fall and are safe doing any daily activities," Despres explains. "For pain management, we teach them strategies of using ice without harming their skin; we might teach tissue mobilization."

To prevent surgery patients from developing chronic pain, physical therapists teach them how to balance their movements. If pain causes patients to bend forward while sitting, the physical therapist will teach them to arch their backs backward after sitting for a long time, she says.

"We teach them how to allow their scars to heal and how to protect healing," she adds. "Once they've healed after the surgery, we can provide body mechanics training and how to mitigate swelling and manage pain, preventing further issues like blood clots and muscles from atrophying."

As patients continue to heal and improve, physical therapists can help with low-level strengthening and improving their range of motion, eventually moving into supporting patients' functioning.

• **Chronic pain.** From a physical therapy perspective, chronic pain can be a mystery to solve.

"The first thing we have to do is jump in and figure out what's causing the problem," Despres says. "Look at the big picture: Why is the person still hurting today when the injury was two years ago?"

Physical therapists evaluate patients' joint tissues and assess their clinical status and ability to engage in daily activities.

For example, a patient with chronic pain might be unable to cook a meal because he or she cannot bend down to pick up pots and pans and can't stand for more than a minute at a time.

"So we'd say, 'OK, cooking a meal is our goal,' and we break it down into smaller steps," Despres says. "Standing is a problem, so how can we get the patient from one minute of standing to five minutes of standing?"

And therapists will help patients change the narrative and description of success. Rather than focus on becoming pain-free as the only viable outcome, they can be taught to focus on achieving small-step success, such as standing for five minutes at a time, bending down to pick up a pot, and cooking a meal, she explains.

"That person realizes that she can do those things and can tolerate standing long enough to cook, and then the pain fades into the background," Despres says. "Then they'll do these activities more and more because they're feeling better and because they have less pain."

• **Chronic illness pain.** Patients with chronic illnesses often experience chronic pain, as well.

For instance, diabetic patients might suffer pain caused by circulation problems, neuropathy, and weight gain.

"Movement helps improve balance, endurance, and strength," Despres says. "Your muscle mass starts to decline as a function of aging, and unless you are doing something to keep strong, you'll lose that muscle mass."

A focus on strengthening and balance can help all patients, including those with chronic illnesses, with their circulation and overall health, she adds.

• **Sepsis.** After a patient survives sepsis, there will be a long recovery period from the infection. These patients need to rebuild their endurance and strength to get back to their baseline health, and physical therapy can help with that, Despres says.

"You want to keep a person moving, so physical therapy comes in and moves all of their joints to make sure they're not atrophied and tightened," she says. "We work with them to do simple things."

Despres once worked with a patient whose abdominal infection required several surgeries. She was bedridden for months and could not stand. "It was a matter of getting her to sit up to tolerate sitting upright, and then to stand and build up the strength she had lost," she recalls.

• **Car accidents.** Patients who are hospitalized after a car accident need physical therapy early on to help them improve imbalances, Despres notes.

"They've been struck and jerked around and have massive impact on soft tissue in their bodies, and a physical therapist can figure out what might be torn, what is more injured and what is less injured, and it helps to manage that early on," she explains.

Chronic pain often develops after car accidents because of imbalances. But physical therapy to help with imbalances and prevent and improve pain can help people recovering from accidents, she adds.

"We give people strategies and specific exercises to manage their pain," she says.

The key is to teach patients life-long strategies to manage their symptoms and prevent chronic pain from occurring, Despres says. ■

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 ReliasMedia.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. **The Department of Homeland Security's proposed changes to the definition of "public charge" would include people who receive public support for medical, housing, and other purposes. Which specific benefit is on the DHS list of programs that legal immigrants receive and that might mean they would not receive a permanent residency status?**

   a. Medicaid
   b. Medicare Part D Prescription Drug
   c. Supplemental Nutrition Assistance Program
   d. All of the above

2. **Based on the Two-Midnight Rule, physicians who determine that an observation patient has been in the hospital for 24 hours and cannot be safely discharged can do what?**

   a. Send the patient to a skilled nursing facility
   b. Upgrade the patient to an inpatient stay, which Medicare would pay
   c. Send the patient home for one day, but have the patient return as needed
   d. All of the above

3. **How many opioid deaths occurred in the United States in 2017?**

   a. 23,300
   b. 38,100
   c. 47,600
   d. 55,800

4. **According to the Department of Homeland Security's U.S. Citizenship and Immigration Services, who would be affected by the proposed change to the "public charge" definition?**

   a. All undocumented people in the U.S.
   b. Every alien seeking admission to the U.S. from any nation, except Canada and Mexico
   c. Individuals seeking immigrant or nonimmigrant visas abroad, seeking admission to the U.S., or seeking to adjust their status from within the U.S.
   d. All of the above

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

Interdisciplinary Care Rounds: A Key Strategy for Improving Case Management Outcomes, Part 1

By Toni Cesta, PhD, RN, FAAN

Introduction

In recent years, emerging best practice care rounding models have changed the face of how healthcare professionals perform rounds. Although these models result in better outcomes for patients, they remain an elusive, often misunderstood tool. When performed well, they can achieve better clinical outcomes, improved coordination of care, improved patient satisfaction, and shorter length of stay. This month, we will discuss how these models are designed and how they can be implemented to achieve desired outcomes.

WHEN PERFORMED WELL, ROUNDS CAN ACHIEVE BETTER CLINICAL OUTCOMES, IMPROVED COORDINATION OF CARE, IMPROVED PATIENT SATISFACTION, AND SHORTER LENGTH OF STAY.

The Joint Commission National Patient Safety Goal 2

The Joint Commission (TJC) developed a series of patient safety goals in 2009. Goal 2 was aimed at improving the effectiveness of communication among caregivers, including standardized handoff processes. Case managers must be aware of both vertical and horizontal communication.

Vertical communication occurs with those to whom we report or those who report to us; for example, communicating with a director or manager, a case management assistant, or a physician advisor.

Communicating with peers is considered horizontal. A majority of the work we do involves horizontal communication. Examples include staff nurses and other members of the nursing department, attending physicians, hospitalists, directors of radiology, laboratory, pharmacy, and other ancillary departments. It is critical that case managers maintain good communication channels with all members of the interdisciplinary care team.

Handoff Communication

TJC's National Patient Safety Goal 2 emphasizes the importance of handoff communication. Crucial handoffs for case managers include:

- RN case managers and social workers;
- case management department staff and providers at the next level of care;
- staff nurses and case management staff;
- physician advisors;
- ED case management staff and inpatient case management staff.

It is during these handoffs that patient information is shared and exchanged. These handoffs should include information about the patient's discharge planning process and insurance, family, social, or financial issues impacting his or her stay or discharge plan.

Strategies for effective handoffs include:

- Ensure communication is interactive and includes opportunity for questioning.
- Shared information should be as current as possible, including the patient's plan of care, treatment and services, condition, and any anticipated changes. Also include information related to the discharge planning process, insurance issues, or family dynamics.
- Handoff communication should include a

verification process for the received information, including repeat-back or read-back, as appropriate. There should be an opportunity for the receiver to review relevant patient historical data. These data may include previous care, treatment, and services.

• Limit interruptions during handoffs to minimize the possibility that information would fail to be conveyed or would be forgotten.

Handoff Communication Methods

There are a variety of methods used in hospitals that fall under the broad category of handoff communication. Some of these methods often are confused with interdisciplinary care rounds. Each method has different goals and objectives, but none should replace interdisciplinary rounds.

Change-of-Shift Rounds

Change-of-shift rounds typically are conducted by the department of nursing, although hospitalists often use this technique as well. These rounds allow for the traditional interchange of clinical information during shift changes. They take place between staff RNs or hospitalists. They are not interdisciplinary, which separates them from other types of rounds.

Shift rounds address bedside care, assessment, and outcomes. Because of their heavy clinical focus, they should be conducted separately from other types of rounds and should never be incorporated with interdisciplinary care rounds.

Teaching Rounds

Teaching rounds generally are used in teaching hospitals as a mechanism for educating medical students, interns, and residents. They provide an opportunity for the attending physician or hospitalist to lead an in-depth discussion of the patient's clinical state, achievement of clinical goals, and expected outcomes. As with change-of-shift rounds, teaching rounds should not take place during interdisciplinary care rounds, nor should they replace them.

Patient Care Conferences

Patient care conferences are an adjunct to walking rounds. These typically occur when it becomes clear that there are additional information or issues that are too time-consuming for walking rounds. Patient care conferences may include a family member if necessary. Items that may be discussed during a patient care conference include end-of-life issues, family barriers or disputes, or other obstacles to a safe and effective discharge.

Huddles

Huddles may come in many forms and with many different names. For this discussion, we will consider huddles as a mini version of patient care rounds. Huddles in this context are used as an adjunct, or follow-up, to the morning's interdisciplinary rounds.

When the hospital holds interdisciplinary care rounds in the morning, huddles are conducted in the afternoon as a means of following up on any outstanding issues identified in the morning. The best way to conduct huddles is through routine schedule; however, there may be an occasion where an unscheduled, or impromptu, huddle may be necessary.

In attendance at the huddle should be the staff nurse responsible for the patients being discussed, the case manager, and the physician if possible. It also may be necessary to include the social worker if the outstanding issues or problems require his or her input.

It is important to plan for a huddle just as one would plan for any kind of rounds. It is best if scheduled huddles take place at the same time each day. A recommended time would be 2 p.m.; this time allows for any interventions that may need to take place before the end of the day.

Each discipline attending the huddle should come prepared with

patient outcomes that have been reached, questions to be addressed to the other team members, or concerns that may need to be raised. It is not necessary to include every patient in the huddle; rather, those patients who have any outstanding issues that had been identified during the morning's interdisciplinary rounds should be discussed.

Huddles allow the team to close the loop on anything that might delay or slow the patient's care progression or achievement of expected outcomes. Clear delineation of each huddle member's roles and responsibilities should be well understood in advance of starting any kind of huddle process.

Internal Patient Transfers

It is not uncommon for patients to be transferred from one nursing unit to another during the course of their hospitalization, or from the ED to an inpatient unit. During these patient transitions, case managers should ensure a standardized, consistent handoff process; otherwise, the case manager receiving the patient may have to duplicate work — which can increase the patient's length of stay and otherwise slow the patient's care progression.

A soft handoff should include a written summary from the staff member transferring the patient as well as any other needed documentation. The summary should include any issues specific to the patient's care plan, discharge plan, family dynamics, and insurance, among other details. Hard handoffs include a verbal exchange of information in addition to any written materials.

Case managers and social workers should see handoff communication related to internal transfers as a hardwired and mandatory part of their daily practice.

Discharge and Interfacility Transfers

When the patient is discharged or transferred outside of an organization, a hardwired handoff process should be used. The process may be dependent on the patient's destination once he or she leaves the hospital.

HUDDLES ALLOW THE TEAM TO CLOSE THE LOOP ON ANYTHING THAT MIGHT DELAY OR SLOW THE PATIENT'S CARE PROGRESSION OR ACHIEVEMENT OF EXPECTED OUTCOMES.

The following professionals should be included in the process:

- Nursing Home: Case management and the physician;
- Home Care: Case management;
- Acute Care: Physician, staff nurse, and case management;
- Home: Primary care provider;
- Home: Family and/or family caregiver.

When discharging a patient home, the family and/or family caregivers should be part of the handoff process. They should be given written and verbal handoff information so that they can participate in the patient's care as comprehensively as possible. Never assume that family or family caregivers understand all that is necessary to take care of their loved one, even if they have done so in the past.

Each time a patient is transitioned, changes in the patient's condition and/or care plan will require that up-to-date information be provided to the family so that the transition and the continuing care needs of the patient are adequate, with as few gaps in care as possible.

Interdisciplinary Care Rounds

Interdisciplinary rounds, including walking rounds, are a key care coordination strategy. Coordination and facilitation of care are among the key roles for RN case managers and social workers. It has become evident that interdisciplinary rounds are a key strategy for ensuring that the entire team is involved in the care coordination process and that these interventions take place in a timely manner.

Rounds, whether walking or in a conference room, provide a real-time and in-person exchange of information. They provide an opportunity for the goals and plan of care for each patient to be clear to all members of the patient's care team. If structured properly, they provide a formal and organized approach to patient care.

Also, if they are structured as walking rounds, part of the process includes time at the patient's bedside. By conducting rounds at the bedside, there is greater assurance that the patient and family receive consistent and accurate information. The patient and family

will receive the information and the messages being conveyed once rather than multiple times from multiple members of the care team. There is less likelihood that information will be conveyed in a contradictory or redundant way, a major dissatisfier for patients and families. Finally, rounds increase the efficiency and safety of patient care.

Why Walking Rounds?

The National Academy of Medicine (NAM; formerly the Institute of Medicine) promotes the use of interdisciplinary care rounds as a means of promoting collaboration. NAM emphasizes that when performed properly, evidence-based clinical management processes can be used by the entire care team in a consistent way. Standardization can reduce variation and/or delays as the entire care team is together when decisions are being made.

Why walking rounds rather than conference room rounds? Walking rounds enable all members of the team caring for the patient to offer individual expertise and contribute to the patient's care from their professional point of view. The various disciplines can come together to coordinate the patient's care as a group rather than individually.

For example, the physician can provide the plan of care and expected outcomes for the patient; the case manager can discuss barriers to patient care progression; and the social worker can discuss family dynamics that may slow the discharge process. This format improves communication among and between the team members.

NAM EMPHASIZES THAT WHEN PERFORMED PROPERLY, EVIDENCE-BASED CLINICAL MANAGEMENT PROCESSES CAN BE USED BY THE ENTIRE CARE TEAM IN A CONSISTENT WAY.

Better communication results in better care, reduced cost, and improved patient outcomes. The Institute for Healthcare Improvement (IHI) and TJC have both documented their support for the use of walking rounds.

The Center for Patient Safety also has advocated walking rounds, saying that the old paradigm was to tell staff to figure things out and just get it done. In the new paradigm, in order for healthcare to have consistent results, healthcare providers must do things the same way every time.

Walking or bedside rounds are critical to patient flow and throughput. By organizing the work of the care providers as a team, delays can be identified and corrected. Redundancy can be reduced or eliminated.

As discussed above, rounds are not nursing report or physician change of shift. When rounds are reported as taking too long, this often is due to the team getting off topic or spending too much time on one patient. Rounds should focus on the following:

- the inpatient plan of care;
- expected outcomes of care;
- barriers to care;
- transitions in care (one level of care to another);
- discharge.

Summary

Now that we have set the stage for why rounds are so critical to improving patient care and outcomes, next month we will continue our discussion by reviewing how rounds should be organized and conducted to maximize their benefit and improve patient care. ■