HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Case Management Trends in 2019 Include Focus on Value and Pathways to Success

Best practices in care coordination help

The healthcare industry in 2019 is experiencing accelerating change, particularly as it relates to care coordination and the shift to value-based care. Trends that took root about a decade ago are growing, creating more opportunities for case managers.

The Centers for Medicare & Medicaid Services (CMS) is moving the industry further in that direction by issuing a final rule for the Medicare Shared Savings Program. Called Pathways to Success, the rule was finalized on Dec. 21, 2018. *(More information on Pathways to Success is available at: https://go.cms.gov/2UVtn7p.)*

> HEALTH SYSTEMS HAVE BECOME INVOLVED WITH ACCOUNTABLE CARE ORGANIZATIONS BECAUSE THEY NEED TO, BUT THEY ARE CONFLICTED ABOUT THE MODEL.

CMS issued the rule that formed Pathways to Success after seeing positive outcomes from the work of accountable care organizations (ACOs), says **Rebecca Perez**, BSN, RN, CCM, director of product development for Fraser Imagineers and the Case Management Society of America (CMSA). She also is the executive director of the CMSA Foundation.

The point of ACOs is to reduce ED

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visits and returns to the hospital. ACOs want patients to use primary care services instead, she says.

Many of these patients would remain healthy if they regularly visited primary care providers and focused on maintaining their health instead of only seeing doctors when they have problems that require an ED visit, she says.

CMS and other healthcare payers are beginning to recognize that one way to improve healthcare costs is to build on the current cultural trend of consumerism — the Netflix model, Perez notes.

When people are offered a better choice, more convenient services, they will steer toward those — like people switched from rental stores to Netflix.

"Rather than the patriarchy model of healthcare dictating what you have to do, it's a move toward a model of the patient telling us what they want to do," she says.

The idea is to offer patients more choices, which improves their healthcare engagement because they feel they are in control of their own health.

"If people feel in better control, there is shared decision-making and they are more likely to make better decisions," Perez says.

This is where ACOs and Solutions for Success come in. ACOs can be more flexible and creative, which could enhance patient engagement. Some ACOs have been remarkably successful. The better outcomes are related to the ACO being a less bureaucratic, physician-led organization that hires case managers, she notes.

"The original plan was that the sharing of cost savings would be implemented over a longer period of time, but CMS saw that smaller ACOs led by physicians were achieving better outcomes than big, hospital-led ACOs," Perez says. "The little guys were doing better than the big guys, and that pushed CMS to tighten the timeline that ACOs have to start taking risk in order to share in cost savings."

Health systems have become involved with accountable care organizations because they need to, but they are conflicted about the model, says **Gary Pritts**, president of Eagle Consulting Partners in Cleveland.

"What I mean is the biggest hospitals receive the biggest chunk of healthcare funding; they're the beneficiaries," he says.

The ACO model provides financial rewards for reducing costs and increasing quality, but the financial incentives are less tangible for hospitals, which under the ACO

EXECUTIVE SUMMARY

Change is in the air this year, and it is moving the focus more toward case management work in care coordination and value-based care.

- The Centers for Medicare & Medicaid Services (CMS) recently issued a final rule for the Medicare Shared Savings Program, called Pathways to Success, to emphasize care coordination.
- One goal is to help people maintain better health and avoid ED visits and preventable hospitalizations.
- CMS wants more focus on value-based care and less focus on fee-for-service care.

model have to work more to receive less money, he explains.

"If Medicare ever goes to full capitation, hospitals will know better how to do it and have systems in place because they're learning how to do it now," Pritts adds.

But hospitals don't want to move to ACOs too quickly because they'll lose funds, he says.

For physician-owned ACOs, there is less conflict. They save the ACO money by keeping patients out of the ED and hospital, and they share in those savings. "Physician-led ACOs are the ones that are able to push the envelope and get significantly more cost savings and better results," Pritts says.

Some physician-led ACOs are embedding case managers in hospitals and partnering with hospital case managers to improve collaboration. Others are contracting with case management providers or focusing on team-based, interdisciplinary models for care, Perez says.

These trends will continue with Medicare's Pathways to Success, which was established to set value goals for ACOs, including accountability, competition, engagement, integrity, and quality.

"It is my understanding that the incentive to do this is reimbursement," Perez says. "CMS is looking for everybody to move away from the fee-for-service model and move to a value-based payment model."

CMS is not forcing this shift but is providing incentives to move in the value-based care direction, she adds.

Organizations following the pathways will need to improve care coordination and focus on creating a safer and higher-quality journey for patients and caregivers, says **Cheri Lattimer**, RN, BSN, executive director of the National Transitions of Care Coalition in Prescott, AZ.

"I see the same focus I've seen for the last five to 10 years, using a collaborative care team focus with patients and family caregivers," Lattimer says. "This includes using professional case managers to assist and support the family and family caregiver, involving them in shared decision-making, understanding their expectations and priorities."

ACOs, bundled payment models, and Medicare have helped spread case management services.

Health system ACOs are good practice for a future in which Medicare might operate fully in a capitated environment, Pritts says.

"The introduction of ACOs and CMS' move toward value-based care brings the case management concept to greater use," he adds. "ACOs are the one place where case managers are part of the whole strategy."

Independent payers followed CMS' lead, also driving the industry toward more case management, Pritts says.

For example, CMS' Pathways to Success allows physicians and practitioners in ACOs to expand use of telehealth and provide patient beneficiaries with financial incentives to maintain good health.

The CMS 2019 Physician Fee Schedule Proposed Rule also includes changes that will fuel a drive toward case management, including policies related to telehealth and remote monitoring. *(More information is available at: http://bit.ly/2N2hzh9.)*

"There is a new reimbursement for remote patient monitoring, a Medicare-reimbursed service for patients with chronic conditions," Pritts says. "This includes blood pressure monitoring, glucose monitoring, and weight monitoring."

For example, patients can use an electronic scale that sends their weight to the physician's office daily.

"This new reimbursement that is available permits care management, and the question is who will do that care management," Pritts adds.

The traditional role of case managers also is needed as so much of the hard work involved in keeping patients healthy and adherent to their treatment involves optimal care transition and coordination, communication and education, and psychosocial supports.

Simply giving patients written discharge instructions will not accomplish the goals, Lattimer says.

"We need quality transitions, and to do that we need good communication between the patient, family caregiver, and patient care team," Lattimer says. *(See strategies to improve care transitions, page 40.)*

The Medicare Pathways to Success offers significant opportunities for case managers, Perez says.

"These rulings create a lot of flexibility in improving performance for ACOs, and the requirements actually encourage them to innovate and expand access to higher quality services that are more convenient for patients," she says. "For example, telehealth: I think we'll see significant increases in the use of telehealth because it can keep people in their homes."

Someone will need to monitor telehealth services and provide patient engagement, she notes.

"The Pathways to Success also allows health organizations to offer patients incentives to do preventive care," Perez says. "These could be monetary incentives to get your colonoscopy or mammogram. These could be vouchers or a gas card."

As long as a provider can show that the voucher connects to the patient receiving the necessary healthcare services, they are allowed. "It's all about bringing people back to primary care and getting necessary follow-up care," Perez says. ■

Care Transition Bundle Outlines Seven Strategies

The National Transitions of Care Coalition (NTOCC) uses seven key elements that help health systems adopt value-based care. The NTOCC's care transition bundle essential intervention includes the following categories:

• Medication management. "Case managers have a role in better medication management and medication reconciliation," says **Cheri Lattimer**, RN, BSN, executive director of NTOCC in Prescott, AZ. "Case managers over these last 10 years have been coached to ask patients medication questions."

These questions include:

- What do you have in your medicine cabinet at home?

- What drugs are you buying over the counter?

- Are you taking any natural health supplements on top of that?

- Do you buy any medication through mail order?

- If you live in a border town, do you cross the border to pharmacies to get medication?

Case managers also can ask tough questions about patients' substance abuse and pain medications, she adds.

Much of this medication management can be accomplished through these types of questions, but the optimal strategy is a home visit. "With geriatric patients, it's not unusual to find medications that have not been reported by the patient but are in the home," Lattimer says.

"Someone visiting the home might find the patient is already on a beta-blocker that was not documented," she adds.

Medication management and reconciliation are low-hanging fruit, and case managers are well suited to assist, Lattimer says.

• Transition planning. The goal is excellent follow-up care from one transition to the next.

"Professional case managers in the hospital should ensure that wherever the patient is going, from whatever care, they can make sure information is transferred from the next case manager in that area," Lattimer says.

"You don't have to own everything, but you do have to be accountable to share information with the next level of care for continuity of care," she adds. "If the hospital patient needs follow-up, then make that follow-up call."

In advanced accountable care organizations, care coordination is successful when case managers help coordinate patients' transition to the next level of care.

"It comes back to communication and good care coordination," Lattimer says. "One does not occur without the other; those two are key."

• Patient and family education and engagement. Focus on patient and caregiver education and shared decision-making, Lattimer advises.

"Just writing out a transition plan with instructions and handing it to the patient is not shared decision-making," she says. "Case managers should take time to sit down and go over information even before the plan is complete, and ask the patient and caregiver if the information makes sense and if they are able to follow the instructions."

When creating a plan, case managers help patients eliminate obstacles to fulfilling the plan. If there is a follow-up doctor's visit in four days, then the case manager might ensure the patient has transportation to get to that appointment, Lattimer says.

"Make sure you agree on a plan," she says.

For instance, if the patient is seriously ill and must decide on the next course of treatment, the case manager can help the patient share his or her treatment preferences.

"If we just write a prescription for the patient and that treatment is not in the patient's mindset, then we'll soon have the patient back in the hospital," she explains.

Without obtaining the patient's engagement and agreement, the patient may not comply.

"We have to make sure — before we send them home — that they have agreed to follow through with the treatment plan," Lattimer says. "Sometimes, these plans fall apart when the patient gets home because we talk to patients when they're in a hospital bed and they may not always understand us."

• Information transfer. Information about the patient's health and care should be shared among the patient, caregiver, and healthcare providers as timely and effectively as possible.

Health systems need electronic health records and should be able to share medical information between providers. For example, a health system can use a transfer tool, transition record, transition summary, or a web-based care management tracking tool, according to NTOCC's care transition bundle. *(Read more about the transition bundle at: http://bit.ly/2E9B1FJ.)*

But electronic records and coordination tools are not always enough to ensure efficient information transfer. Health systems also need to make sure their electronic records can capture critical case management information related to care coordination.

"Often times, case managers' assessment notes in support of patients' preferences is hard to find in electronic health records," Lattimer says.

Without ready access to information about patients' preferences and access obstacles, healthcare providers will lack necessary information for a successful transition.

"The professional case manager takes time to collect all of this information and communicates it, but if it's not clearly available in the electronic health record, then we've lost an important part of the documentation," Lattimer says.

"Communication is the most important piece of care coordination," she adds. "We can use all the tools and checklists, but if we're not coordinating this from one level of care to the next and communicating this clearly, then we're losing ground."

If providers do not receive information on the patient's care plan and repeat what case managers have already said, patients might stop talking and become disengaged.

"If we ask the same questions over and over and we're not documenting it or looking at it in advance, then patients might say, 'I've given this information before, and I'm not going to do it again,'" Lattimer says.

• **Follow-up care.** "I think 80% of the time a patient and caregiver will get home and within 24 hours they will say, 'What did that nurse say, or the doctor says I'm supposed to do what?'" Lattimer says.

Effective transition planning depends on thorough assessments, documentation, and communication. But it also depends on case managers following up to ensure patients know what to do once they leave the hospital and are able to take the next steps in their medical care.

"Once a patient has left the hospital that follow-up call might be the next [healthcare contact] they have," Lattimer says.

Case managers also can confirm patients' physician follow-ups and make appointments for post-discharge testing. They can arrange for provider home visits soon after discharge. They also might call patients to reinforce the transition plan and see whether patients have any issues that should be resolved, according to NTOCC's care transition bundle.

For instance, case managers can help patients connect with area nonprofits that provide meals and other services if patients have trouble with activities of daily living on their own.

• **Healthcare provider engagement.** Every provider involved in a patient's care and transition should know what is going on, and it often is case managers' responsibility to share information and increase engagement, Lattimer says.

The case manager's role also includes improving documentation around the patient's condition, making sure providers in the hospital and in the community have access to information about the patient's hospital and/or ED admission, reconciling medication lists, and essentially serving as a communication hub, according to NTOCC.

Patients should be coached on self-care management and how to identify signs of medical problems.

• **Shared accountability across providers and organizations.** Physicians do not shoulder the entire responsibility. There is shared provider accountability, and this includes the clinical care team and case management team, Lattimer notes.

The patient's plan of care should be communicated clearly and timely to patients and providers on the care continuum, the NTOCC care transition bundle states.

The key in transition planning is a thorough assessment by the professional case manager, sharing the assessment with all involved providers and with the patient and caregiver, Lattimer says.

All of those involved must interact with each other, document all actions taken, and put the care plan in place to meet the patient's and caregiver's needs after the patient has left the hospital, she adds.

"The case manager has the role of assisting with core communication," she says. ■

Value-Based Care Requires Support for At-Risk Populations

As healthcare systems move further into value-based care, case management departments increasingly will need to focus on providing support to at-risk populations.

Case managers should learn how to better work with patients most vulnerable to hospitalization and build relationships with them, says **Rebecca Perez**, BSN, RN, CCM, director of product development for Fraser Imagineers and the Case Management Society of America (CMSA). She also is the executive director of the CMSA Foundation.

"When you're working with individuals at high risk, they're at high risk because they face multiple challenges, and often those challenges are social," Perez says. "By developing a trusted relationship with them, you can better address those challenges. Sometimes, working on those challenges first helps them achieve better health outcomes."

And the need to build trust is important when dealing with other healthcare professionals and case managers. For instance, another challenge for hospital case managers is learning to work with payer and community case managers, she notes.

There have been cultural and some structural obstacles to case managers communicating with each other between the hospital, community, and payer settings, but this should change, Perez says.

"Especially with the way reimbursement is going to value-based payment and team-based approaches, case managers — regardless of the practice setting, and with information that's going to be shared and not isolated — all have to think about what's best for the patient," she says.

"If you're hospital-based, you only have that episode, and there has to be a handoff somewhere," Perez explains. "Whether it's to an insurance-based case manager or long-term care, there has to be that handoff."

This is why it's so important that hospital case managers learn to develop trust as they communicate patient information to the next provider and case manager, she adds.

Perez suggests case managers facilitate better handoffs and relationships throughout the care continuum by following these suggestions:

• **Build trust.** The way to do that is to reach out to payer partners, developing relationships and processes for physicians. This can be through embedding case managers in facilities' transition teams.

"It's easier to build a relationship if you have a face, a physical presence, rather than just a phone and utilization review manager to talk to," Perez says.

Case managers can develop relationships and build trust with payer groups, as well. This helps with transitions.

"They'll know who they're talking to and who they're dealing with," Perez says.

"If they don't reach out to you, then you reach out to them," she adds. "If the hospital case manager waits for the payer to reach out, and vice versa, then no one will accomplish anything. It's about being proactive."

• **Reach out to payers.** After years of distrust between hospitals and payers, it is time to get rid of that culture and focus on the patient. Case managers can be the first to take the initiative, Perez says.

"There are situations where certain payer structures are strictly telephonic," she says. "Now, the trend is moving toward doing more face-to-face interactions."

Payers might still only interact with hospital case managers and providers through conference calls, but relationships can build on that interaction as well. Case managers can offer to introduce payers to the transition team and discuss discharge planning processes, Perez says.

"That relationship gets established and each person knows who they're working with and who the payer team is," she says.

• **Talk about alternatives.** Case managers should have a list of available options. When a patient does not want to go to a long-term care facility, his or her case manager should be able to offer an alternative plan that allows him or her to stay at home with all necessary supports, Perez says.

The case manager can say to the payer, "We believe this support will prevent her from being readmitted, and it will save money over the long-term care facility. Would you be open to that?" she says.

It helps to collect cost and outcomes data. The case manager might bolster the case by adding, "You will save 17 days of skilled nursing facility per diem costs by having these services in place," she explains.

"The hospital case manager needs to put that plan together and present it to the payer," she says. "It helps to have trust between professionals and the patient."

With trust, everyone knows they are working for the same goal of improving the patient's care.

• **Be quick to respond.** "The strategy I always used as a case manager was to make their job easier," Perez says. "I said to physicians and peers and colleagues that I would do whatever I could to support them and to make their jobs a little easier."

And when someone called for a quick turnaround favor, Perez would come through on her promise.

"Even after I stopped working in the field, I would still get calls from facilities, saying, 'I got a transplant patient, will you be the case manager?' and that was years later," she recalls.

"That's how it works," Perez adds. "When they know you are legitimate in your role to support them, then those relationships last."

The key is to be genuine when telling other professionals that everyone is in this together to support the patient and the treatment plan.

Of course, it will not work unless the case manager follows through. "If you're not flexible, you won't last in the field of case management," Perez says.

"I've recruited many case managers over the years that I thought would be really good case managers because

they were so good with patients," she says. "But they were far too rigid, and if you're task-oriented, you won't be a successful case manager when it comes time to fly by the seat of your pants because things change, especially when working with at-risk populations."

With at-risk patients, something might change within minutes, and the case manager must be able to adapt to that change.

"You can have a beautiful care plan lined up and ready to go, and then everything falls apart," Perez says. "So you have to alter that care plan and not see it as a failure because you're always thinking about what's best for the patient."

Anticipate what can potentially go wrong, and always have a back-up plan. Flexibility is imperative in case management, she adds.

• Provide value-based care. Regardless of what happens with the Affordable Care Act, the focus on value-based care will continue to grow, Perez predicts.

"Personally, I see us finally on the right track of paying for performance, rather than just having fee for service," she says. "We're finally putting patients at the center of what we are doing."

This transformation is an adjustment for many healthcare professionals and institutions. Some organizations are developing quality measures and moving toward standardization. And they recognize the importance of case management as the foundational support of value-based care.

"Truly, case management is at the heart of value-based payments," Perez says. "It's all about team-based care and care coordination, and case managers have always done that."

Health organizations' roles of patient navigators, patient advocates, and transition coordinators are all functions of case management, she adds.

"These are all functions of case management that people are piecemealing into great, innovative programs," she notes. "We want to tweak something to make it look fabulous when we have something that works — case management — already in place." ■

Well-Regarded Business Strategies Can Be Used in Case Management

Payers, including the federal government, are beginning to recognize that healthcare providers can succeed with keeping patients healthy only to the extent that patients are willing collaborators in their own care.

If patients refuse medical help when it is clearly needed or when they fail to take their medications and see their doctors, their health problems will continue and medical costs will rise.

One solution developed by a physician with a master's-level business degree and a social worker is negotiation between case managers and patients. It works best when case managers receive negotiation strategies and training that are similar to what are used in business settings.

Case managers will need negotiation tools prior to engaging with a potentially resistant patient, says **Lee Lindquist**, MD, MPH, MBA, chief of geriatrics at Northwestern Medicine in Chicago.

"People want to go home from the hospital and stay in their own home as long as possible, and it often times falls on the case manager/social worker to make it happen," Lindquist says.

Many patients are too frail or too sick after hospitalization to manage on their own, but they still might receive home healthcare and other home medical services. This can jeopardize their ability to maintain good health and stay out of the hospital. The key challenge for case managers is to convince patients to accept the services.

While Lindquist was earning her MBA, it occurred to her that a lot of the information she was learning about business could be taught to healthcare professionals to help them become more effective in reducing readmissions and working with patients, she says.

From this knowledge, she helped develop training programs for case managers about negotiating with patients in refusal-of-care situations.

"We teach courses to case managers about the main reasons people might choose to not receive medical services, and then we teach tactics that they teach at most business schools," Lindquist says.

Successful negotiation begins with understanding the other side's perspective.

"What we see is people are very reluctant for their independence to be taken away," says **Annie Seltzer**, LCSW, CSW-G, a social worker specializing in the geriatrics clinic at Northwestern Medicine.

"Typically, a social worker or case manager will go into the patient's room upon admission and do a full psychosocial assessment in which

they gather data about the patient's living situations, social support, activities of daily living, and what the patient is able to do independently and what the patient needs help with to get a bigger picture of the patient's current functioning," Seltzer says. "From there, they can make recommendations of when the patient is ready to go home."

Hospital providers might recommend the patient be transitioned to a post-acute care facility before returning home. But in Seltzer's experience, patients being discharged from the hospital mostly prefer not to go to a skilled nursing facility or post-acute rehabilitation center as they fully recover, she says.

"We are lucky in Chicago because we have a lot of services for people who want to stay home," Seltzer says.

Home health services can sustain many patients, but convincing patients to accept even this level of care can be a challenge. That is where negotiation tactics can be employed.

"It's the idea they are giving up their independence and need to accept help," Seltzer explains. "The idea of having someone come in and do our cooking and cleaning sounds nice to us, but for people in their 70s and 80s, it sounds like someone is taking away their autonomy."

The first step in negotiation is to ascertain whether the patient is capable of making a sound decision. Some patients have dementia and could manage at home with help, but they might experience difficulty participating in discussions that require a higher level of cognitive awareness, Seltzer and Lindquist say.

"We need to make sure the patient is someone who is able to cognitively make these decisions and remember the conversation," Seltzer says.

Once the case manager is confident the patient is capable of his or her own decision-making, the next step is to ensure the patient feels supported and understands how safety is a top priority of healthcare providers.

"I almost always say to patients in our clinic setting that it's everyone's goal to make sure the patient can stay as independent as possible for as long as possible, while making sure their safety is not being compromised," Seltzer says.

"We want to make sure they feel supported and are treated well and that they're also getting the services they may not think they need," Lindquist adds. "Most people, in their own minds, feel younger than their bodies, and when they are hospitalized they become weak."

So they want to return home and are not convinced they still need help.

"We teach a course that talks about the main reasons people choose not to do home health services and why they resist these," she says. "Then we teach tactics to case managers and social workers that are like the tactics they teach at most business schools."

Participants in the negotiations skills classes also role-play to develop confidence in their ability to negotiate successfully with patients.

One negotiation tactic is to use empathy.

"Patients don't like the idea of losing independence, so we talk about how no one is ever truly independent — we're intra-dependent," Lindquist says.

For example, senior people often have helped other family members and friends — altruism that gives them as much joy as they give to others, Lindquist says.

A case manager can explain how the patient's acceptance of help from home health providers is the same thing.

"We help seniors understand that by accepting someone into their home, they're giving the person an opportunity to experience joy," she explains. "This type of reframing — spin tactic — gets past their resistance."

Reframing is a psychological strategy to change the way one looks at a situation in order to shift an emotional reaction or state. It can be used by therapists and others to build resilience and help someone go from feeling negative about a circumstance beyond their control to viewing the same circumstance from a more positive perspective. *(More information is available at: http://bit.ly/2V0PBoN.)*

Focusing on the joy of helping someone gives the patient a new way to view his or her home health services.

"We're reframing it so it's not about the senior as much as about the people around them," Lindquist says. "We always teach case managers to be more positive: Instead of 'You need help; you're having problems in your home,' it's a more positive message of 'If you accept someone in your home, you'll be helping them.'"

Before engaging in negotiation with patients, case managers will need to prepare. Practicing negotiating tactics can help, and this is where role-playing is helpful.

For instance, case managers could practice how they would handle patient resistance in specific, real-world cases. Through practice, they grow more comfortable with negotiating tactics and with working with patients to improve their engagement with healthcare services.

"It's collaborative with patients," Seltzer says.

"This is a good way to respect patients' autonomy and have them participate in their own decision-making." ■

Pediatric Hospitals Develop Best Practices to Avoid Readmissions

More than 135 children's hospitals nationwide have shared best practices and strategies for improving safety and health outcomes for their young patients. The Children's Hospitals' Solutions for Patient Safety (SPS) is a collaboration that has helped some hospitals reduce their readmissions rates and improve safety and care quality.

This group of children's hospitals has taken the bundles of care approach, applying a bundle of their best practices to see how these impact outcomes, says **Cyndi Fisher**, RN, MSN, CPNP, ACM, director of case management and care connection at the Children's Hospital of The King's Daughters (CHKD) in Norfolk, VA.

"We did that at The King's Daughters for readmissions," Fisher says.

Dayton Children's Hospital was one of the original eight Ohio hospitals that banded together to form a collaboration on safety.

"Originally, we were called the Ohio Children's Hospital Solutions for Patient Safety," says **Hila Collins**, MS, RN, CPNP-AC, CIC, director of clinical safety at Dayton Children's Hospital.

"Now that we're national — and international with Canada hospitals — we're just Solutions for Patient Safety," she says. "When we sat at the original table in Columbus, OH, we wanted to make it very clear that our mission was to eliminate harm."

The Ohio children's hospitals are competitors, but not when it comes to patient safety: "We made a very intentional decision that it was much more important that we could teach and learn from one another about pediatric patient harm reduction, and there was not going to be any competition," Collins explains.

The SPS National Children's Network has a goal of harm reduction by Dec. 31, 2021. The goals include improving pediatric care and cutting Medicaid costs. *(For more information, visit: https://bit.ly/2SbnKQP.)*

"If there is one hospital among the 135 that has something working very well, then they'll talk about it so we can implement [best practices] at our place," Collins says. "We have an overarching philosophy of adopt, adapt, or abandon."

At CHKD, best practice strategies are working: Internal data show reductions in both seven-day readmission rates and 30-day readmission rates, Fisher says.

For example, CHKD's internal data show that in 2015, the seven-day readmission rate was 4.23 per 100 discharges. This had declined to 3.19 per 100 discharges in 2017 — a reduction of nearly 25%. Also, the 30-day readmission rate dropped by about 16% in that same period of time: it was just over nine per 100 discharges in 2015, and it fell to 7.57 per 100 discharges in 2017.

Hospitals involved in the Solutions for Patient Safety learn small safety best practices, such as using visual cues that remind staff that a patient is at risk of falling. They might share more complicated strategies like using an algorithm in the electronic medical record to inform decision-making about patients' vital signs, Collins says.

"We focus on hospital-acquired conditions and one top one is catheter-associated urinary tract infections [CAUTIs]," Collins says.

After setting a goal of reducing CAUTIs, the hospital developed best practices from research findings and learned strategies from other hospitals. The result was a reduction of more than 30% in catheter days and no CAUTIs over a two-year period, she says.

CHKD achieved the positive readmission outcomes through several best practice steps, which include having case managers help patients eliminate obstacles to maintaining their health. These best practice steps include the following:

• Identify readmitted patients.

"If patients return to the hospital and we have a readmission, that's where we identify opportunities for improvement," Fisher says. "If the patient returns within seven days, we look at this to see if this was a planned or unplanned hospital stay, and then we do a chart review."

For example, the chart review might reveal that the patient never scheduled a follow-up appointment.

On some of the readmissions, there will be a family survey.

"We want to see what their experience was and if the readmission could have been prevented," Fisher says. "Additionally, we notified both the physician discharging the patient as well as the physician readmitting the patient to see if there was anything from their perspective that could have made this encounter avoidable."

For example, if the patient did not take antibiotics after hospitalization for an infection, then the patient's illness could continue or a secondary infection might occur. "We're dependent on the parents to follow through on the things they need to do," she says.

In another example, a patient might be discharged with an order for oxygen at home. If the durable medical equipment (DME) company doesn't provide the oxygen equipment before the child's bed time, the family might have no choice but to bring the child back to the hospital to ensure the child can sleep safely through the night, she adds.

"We have to depend on the home care company and DME company to do what they need to do for the family," Fisher says.

• Design best practice processes.

"Everybody approaches best practices their own way at their hospital," Fisher notes. "Ultimately, I think these should be based on the research and work that's been done at readmissions."

For example, CHKD staff identified helpful practices, such as making sure that families at discharge scheduled follow-up appointments and had a contact number for those appointments.

Also, patients identified as high-risk for readmissions because of their dependence on post-acute services or medications receive post-discharge follow-up calls, Fisher says.

For instance, the patient might be in the hospital for treatment of an infection. The patient is weaned off the IV antibiotic but now is prescribed a regimen of oral antibiotics to prevent recurrence. This patient's family could benefit from a follow-up call to confirm that the family was able to pick up the medication within two days. If the family could not afford the medication, then a case manager could help them obtain a voucher. Or if there was a delay because of insurance authorization, the case manager could call the patient's pharmacy benefit manager to get authorization, taking care of whatever barriers arise, she explains.

• Follow-up with case management.

"We provide the care, reinforce what it is the family needs, and we make sure they're in good shape," Fisher says. "Then my administration team does a post-discharge follow-up phone call to make sure they have everything they need."

The initial phone calls follow a script, such as this one: "Hi, this is nurse from case management. I am calling to check on how things are going since you were discharged from the hospital…"

The caller asks questions, such as these from the CHKD case management discharge follow-up survey:

- Did you feel prepared to care for your child at home after discharge?
- Did the home services agency/ agencies contact you as planned?
- When are you scheduled to follow up with your child's physician?
- Were you able to obtain the prescription or formula that was ordered?

"We document responses," Fisher says.

If the family has a concern or if there is a problem, the caller obtains the family's best contact phone number and refers the patient to the case manager for further follow-up, she adds. ■

Children's Hospital Develops Tool to Improve Throughput

Changes in regulatory and reimbursement factors are making it more likely that children's hospitals will follow in the footsteps of health systems and focus on improving patient throughput and reducing readmissions.

"Historically, children's hospitals have not had to have a focus on managing length of stay or managing throughput," says **Lesly Whitlow**, DNP, MBA, RN, vice president of access and care coordination at the Ann & Robert H. Lurie Children's Hospital of Chicago.

"We weren't impacted by DRGs [diagnosis-related groups] and all contracts were per diem, so there never was an emphasis on length of stay or managing throughput," Whitlow says.

For children's hospitals in Illinois, this changed when the state introduced DRGs through Medicaid several years ago, she says.

"When that happened, we had to start looking at our practices and look at our healthcare environment, which was changing, and we had to be proactive in managing that," Whitlow explains. "That's when it started to shift."

The shift meant children's hospitals would need to look at discharge milestones, DRGs, and length of stay (LOS).

"It wasn't until this fiscal year when we were looking at length of stay and a few DRGs to get best practices in place," Whitlow says. "For the last fiscal year, we started to look at how we could improve or move up the time of day when patients are being discharged."

For example, there are patients

whose parents do not arrive until the late afternoon or evening, so their discharges mostly occur between 3 p.m. and 7 p.m. or 4 p.m. and 7 p.m., she notes.

"We wanted to move that up to have beds available for patients earlier in the day," Whitlow says. "So we started looking at discharge milestones."

The hospital's baseline percentage of discharges by 2 p.m. is under one-third. One goal is to increase that to 40% discharges by 2 p.m., she says.

When the hospital underwent an electronic health record upgrade, they defined discharge milestones, describing discharge tasks that would be the focus in improving throughput and increasing the proportion of earlier discharges, Whitlow says.

"Discharge planning starts at admission and involves understanding the patient and family and their normal daily activities," she explains. "How can we ensure they have transportation to pick up the child at 2 in the afternoon instead of 5 in the evening?"

A key step in creating a more efficient discharge is knowing patients' and families' schedules. Healthcare staff and case managers also should understand clinical criteria for discharge. And they need to help patients and families set expectations about discharge so they can work together toward the same goals, she says.

"Our goal was to increase the discharge time from an average of 4 p.m. and 5 p.m. to 2 p.m.," Whitlow says. "This change allows people to enter beds in the later afternoon."

There were some structural changes that the hospital could make, including ensuring the patient transport team was ready for an earlier discharge. And there were cultural changes that proved more challenging, such as facilitating earlier attendee or resident rounding on patients who are to be discharged that day, she explains.

"We need to discuss how we might facilitate attendees and residents rounding on those patients that might be discharged that day," Whitlow says. "We need to talk with them about rounding on discharge patients first so the resident can follow behind them and get all of the paperwork done."

The hospital hasn't made the change yet to prioritize rounding on patients identified for discharge. That is a goal and would be a big change, requiring more staff education, data tracking, and data sharing, she adds.

Cultural change involving physicians also requires physician leadership. "Our case management department has a medical director who does a lot of education for physicians and the medical team," Whitlow notes.

"We know what the next step is, and it's really around that culture change with rounding," she adds. "First, we have to get the chief physicians behind us because that's where the change will come from."

The discharge milestones list includes the following:

• **9 a.m.:** Documentation to arrange transportation, social work readiness, and case management readiness is completed.

• **10 a.m.:** Providers complete medication reconciliation. "We need to make sure medication reconciliation is done earlier in the day," Whitlow says.

• **11 a.m.:** Request facility transport. "Our transport team in the hospital makes sure they have the patient on their docket as being discharged that day. So when the time comes for discharge, they are free to come and get the patient," she says.

• **12 p.m.:** Medications should be at the bedside, along with printed discharge instructions. "The discharge instructions should be printed by noon so that the nursing team can review them with patients' families prior to the 2 p.m. discharge time," Whitlow says. "That is our goal."

• **1 p.m.:** Enter discharge order. The physician enters the discharge order; the social worker documents that psychosocial needs are met, and the case manager indicates the plan is in place and the patient is ready to be discharged, Whitlow says.

• **2 p.m.:** Discharge patient.

Case managers help facilitate a timely discharge throughout the process.

For example, they round with the medical team and collaboratively come up with the date of discharge, Whitlow says.

"One thing that's important to understanding an efficient discharge is you need everyone to understand — the medical team, the patient, the family — what the anticipated date of discharge is," she says. ■

COMING IN FUTURE MONTHS

- Integration of care delivery is key focus
- Improve authorizations, denials, appeals processes
- Case managers can help expedite transfers to skilled nursing facilities
- Payer-health system mergers can transform delivery model

HOSPITAL
CASE MANAGEMENT

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CE QUESTIONS

1. **CMS issued a final rule for the Medicare Shared Savings Program to promote a shift toward value-based care, called:**

   a. Solutions for Success
   b. Pathways to Success
   c. ACO Health Leaders
   d. Value and Vision Care

2. **Which of the following is a relevant medication reconciliation question for patients?**

   a. "What is the name of your prescribing physician?"
   b. "What types of fruits and vegetables do you consume?"
   c. "Who in your household helps pick up your medication?"
   d. "Do you buy any medication through mail order?"

3. **When case managers wish to convince patients of the benefits of receiving home health services after they leave the hospital, which of the following concepts might help them with patient negotiations?**

   a. Reframing: a psychological strategy to change the way one views a situation in order to shift an emotional reaction.
   b. Cognitive dissonance: showing patients that they are working against their own interests.
   c. Affirmation: giving patients positive feedback about their own decision-making with a goal of helping them gain enough confidence to make the right decisions.
   d. None of the above

4. **Which of the following is a discharge milestone that a hospital might outline in an effort to move up discharge times?**

   a. Moving up meal time
   b. Social work readiness and case manager readiness
   c. Date of admission
   d. Family members' work schedule

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.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

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

By Toni Cesta, PhD, RN, FAAN

Introduction

In the last issue of *Case Management Insider*, we began to explore the concept of interdisciplinary walking rounds. We reviewed why walking, or bedside, rounds are being promoted as best practice by the Institute for Healthcare Improvement and The Joint Commission. This month, we will discuss the elements of a walking rounds format and the role that the interdisciplinary team members play in the process. Each team member should be aware of his or her unique role so that rounds can be as streamlined as possible. Through standardization and the reduction in variation, rounds will go smoothly and timely.

EACH TEAM MEMBER SHOULD BE AWARE OF HIS OR HER UNIQUE ROLE SO THAT ROUNDS CAN BE AS STREAMLINED AS POSSIBLE.

The Elements of Effective Walking Rounds

When developing a rounding process or updating one in your organization, certain key components should be included. These key components include the following:

• **Identify and refine goals for rounds.** All members of the team should know the goals of the rounds. These goals should remain consistent regardless of the team member or the patient being discussed.

• **Create a structure.** Once a structure has been designed, the team must stick with that structure. Constantly changing the structure will confuse team members, lead to an increase in variation, and reduce the quality of the rounds.

• **Leadership is key.** The leader of the rounds should be consistent. The leader should be trained to ensure that he or she is prepared to manage and lead the rounds. Also, appoint a secondary leader to ensure consistent coverage.

• **Appoint a standard time for rounds every day.** Rounds should always be conducted at the same time. A standard time allows the team members to be prepared and available for the rounds. Rounds should always be mandatory for every team member.

• **Engage with the patient and family.** Including the patient and family in walking rounds is what differentiates walking rounds from other forms of rounds. This allows the patient and family to hear what each team member is reporting and to ask questions.

• **Measure success.** To ensure effective rounds, conduct regular assessments. Data to be included in these assessments will be discussed later in this series.

The Leader and Members of Walking Rounds

Hospitalists typically lead walking rounds. This can be problematic if the hospitalists are not unit-based, but patient-centric. If it is not practical for the hospitalist to lead rounds, then another designee should be assigned. This can be a nurse leader, case manager, or other physician.

Best practice tells us that rounds are best conducted in the morning, either before or after new admissions have been processed. This way, discharges can be handled after rounds are over.

There are key team members who must always be

included in rounds. Other team members can always be added to enhance the rounding process, but this group includes the minimum number of members who should be in attendance:

- physician;
- staff nurse;
- case manager.

These same team members also can participate in the afternoon huddle as was discussed in the last issue.

The Focus of Rounds

The two primary elements of walking rounds include coordination of care and communication. All activities and outcomes associated with rounds stem from these two elements.

Care coordination includes patient care activities among and between the disciplines. It also includes a review of the patient's current status and provides for an opportunity to discuss and clarify the patient's goals and expected outcomes. Through the coordination process, the team can develop a comprehensive plan of care that includes the perspectives and expectations of each discipline.

Communication also is critical to effective rounds. The following are key elements in the communication process:

- reiterate the goals of rounds;
- identify any current or future safety risks;
- educate the patient and family on status and expectations;
- ensure that all team members share a consistent message.

Communication for Rounds

When conducting daily rounds, communication can make or break success. Communication is the foundation of productive and successful teamwork. Consider these points as they relate to communication in walking rounds:

- **Clear:** Each team member must be as clear as possible. Each discipline should refrain from using jargon and abbreviations so that all attendees can easily follow the discussion.

THROUGH THE COORDINATION PROCESS, THE TEAM CAN DEVELOP A COMPREHENSIVE PLAN OF CARE THAT INCLUDES THE PERSPECTIVES AND EXPECTATIONS OF EACH DISCIPLINE.

- **Complete:** All components related to the patient should be included as necessary and discussed in as much detail as needed. If an extensive discussion is warranted, it can continue once the rounding process is complete.
- **Brief:** While communication on rounds should be complete, it also should be brief and without more detail than is necessary.
- **Timely:** Timely communication takes on two forms. First, each patient should take between 60 and 90 seconds; at times, a specific patient may require more or less than these benchmarks. Next, the information provided should be timely. Issues related to the patient that have no bearing on the current admission or discharge plan need not be discussed.

Without effective communication, teamwork cannot exist. In fact, you cannot have one without the other. Let's review some of the most important reasons why communication and teamwork are so interrelated:

1. Prevents errors. Errors can be reduced or prevented through close communication and teamwork. As the team is discussing each member's plan of care, this will be the time that errors can be uncovered. These might include things that were overlooked, or overutilization or duplication of resources. It also can uncover conflicts in the plan that might result in negative outcomes.

2. Minimizes strain. One of the major dissatisfiers for clinical team members is finding a colleague when you need them and when they are available. Trying to grab people on the fly can cause stress and strain on the professional relationship and between the team members. Much of this can be avoided when the team has a structured discussion each morning as a group.

3. Builds trust. Lack of trust within a team can often be related to poor communication between and among the team members. When the team rounds together, communication is enhanced as each team member can hear the other professional point of view and thinking process.

4. Fosters team adaptability. If the team members do not know what the other plans and concerns may be, it is impossible to make adaptations and alterations. They also may be suspicious of changes made by another team member if the rationale is not well understood. Rounds can help alleviate these concerns

through direct communication and discussion.

5. Strengthens the team. Communication is well understood to be a team builder. If all team members are united, the team is strengthened. The whole is greater than the sum of its parts.

6. Increases effectiveness. For all the reasons listed in this section, rounds can increase the effectiveness of the team as a whole as well as each team member's performance. Healthcare has become a complex process. Outcomes are clearly affected positively by a team mentality and better cooperation.

Key Structural Points for Developing Rounds

The following key structural points must be in place as you begin to embark on the journey of putting a best practice rounding process in place. The development of rounds, or the re-engineering of existing rounds, should be undertaken as any change process would be. Without a structured process, the likelihood of success is greatly diminished.

The first point is the assignment of leadership. The leader of the rounding process should be designated and standard. This means that one person is always the leader, with the exception of the days when they are not at work. By keeping the leader standardized, you can better ensure that the rounds are conducted in the same way every day.

The leader should be well trained and educated on the rounds in terms of philosophy, process, and expected outcomes. He or she should be held responsible for rounds starting and ending on time and for the outcome metrics.

The leader can be from any discipline but must be someone who is committed to the success of the rounds. The leader most often is a physician. Hospitalists can be an excellent choice for leading rounds, as they are available and part of the in-patient team. However, if the hospitalists are not unit-based, this may make their role as the leader of the rounds almost impossible. They would not know all the patients on the unit they are leading and would not necessarily be available. This problem supports the argument for hospitalists to be unit-based whenever possible.

HEALTHCARE HAS BECOME A COMPLEX PROCESS. OUTCOMES ARE CLEARLY AFFECTED POSITIVELY BY A TEAM MENTALITY AND BETTER COOPERATION.

The second key structural point is the selection of the specific team participants from the interdisciplinary team. The standard members should include the physician, the staff nurse responsible for the patient, and the case manager.

The additional members should be appropriate to the unit's clinical specialty and other issues of relevance to the clinical area. For example, it might be appropriate to have a clinical pharmacist round on units where polypharmacy issues may be a problem. Geriatric units may be a good location within which to include the clinical pharmacist.

Conversely, on orthopedic or neurology units, adding a physical therapist to the rounding team would be appropriate. The point is to review the specific clinical needs of the unit and staff the rounding team appropriately. Be cautious to not overstaff the team — the members should be manageable and be directly caring for the patients.

One exception might be a pastoral care representative. Pastoral care staff may be important to include on a hospice unit, cancer, or geriatric unit. They may not be engaged with every patient, but they will be able to appropriately select patients while listening on rounds. This allows them to have a proactive approach to identifying patients, rather than reactive.

Setting Daily Goals

Rounds provide an opportunity for the team to set daily goals for the patient. By following this process, the team can ensure that they are moving the patient toward his or her daily outcomes.

The team should provide daily feedback so that the goals can be refined and reset if needed. During rounds, the team may determine that some goals have been completed or additional goals are needed. There also should be an overarching goal for the patient's stay that should be discussed daily on rounds.

Walking rounds provide the opportunity for the team to discuss the daily goals with the patient and the family. When patients and family members understand the goals of care, they are much more likely to be active participants in the recovery process.

One helpful strategy is to document the goals for the day on the whiteboard in the patient's room. Anyone caring for the patient can see

the goals, but even more importantly, the patient and family can see them.

Examples of daily goals include the following:

- wean off oxygen and blood pressure medications;
- get the patient up and walking;
- ensure the patient can eat;
- perform medication reconciliation and ensure everyone understands the treatment plan.

Strategies for Getting Started

One of the first things to consider is the need to leverage any existing rounding processes. As we have discussed, walking and bedside rounds should never be merged with nursing change of shift or teaching rounds. However, if your hospital already uses some form of rounding, that should be taken into consideration. Components of existing rounds can be used as a starting point and can possibly be enhanced. In this way, the team that rounds will feel that you are taking the best of their rounds and building on them, rather than completely throwing them away. This can be a positive way of engaging with the team you are planning on working with to get started.

When conducting a change process, seek out willing participants. They may be those units that already have some form of rounds. Or it may be a unit where there is a hospitalist who is schooled in rounds or who has experienced them at another hospital.

In addition to finding the right unit to start with, another key to ensuring greater success with your first unit is to start small and test often. Starting small means that it may be most beneficial for you to start with that one unit and perfect the processes there before you move on to additional units. Evaluate the steps in the rounding process often as you roll out the first unit. The team should be educated on all of the components before you actively begin the rounds. A specific focus on scripting, time management, or expected outcomes can be helpful in ensuring greater success.

Once you are confident that the team members are educated in the structure, process, and expected outcomes of rounds, you can begin to test out the rounds. For example, a tracking tool can be used to document the start and stop times. The information tracked should be discussed with the rounding team regularly so that feedback can be elicited and changes can be made in a timely manner where needed. The team should be encouraged to give constructive feedback so that they remain engaged in the change process.

Segmenting Rounds

Segmenting rounds refers to organizing which patients might be cohorted together. Typically, this should be based on the staff nurse's assigned patients. In this way, the staff nurse is only required to participate in rounds for the time it takes to round on his or her assigned patients. On average, this should not be more than 10 minutes.

As with anything, there can be exceptions to this rule. If the unit includes a specialty area, it would be beneficial to segment those patients so that rounds can take place with the specialty physician. Some examples include heart failure, respiratory, or surgical specialties. While this type of segmenting can make the rounds structure more complicated to implement, it provides an opportunity for the other members of the team to work directly with the specialty physician. This can provide for much greater efficiency and communication.

Summary

In this section of our series on walking rounds, we discussed the steps you may need to take in order to implement new rounds or refine existing rounds. Next time, we will discuss scripting and strategies each discipline can use to prepare for, participate in, and conclude rounds. ■