HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

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INSIDE

RELIAS MEDIA

Hospital Case Managers Can Learn From Lean

Reduce waste, improve quality

By Melinda Young

One effective way for hospitals to improve patient care and reduce rehospitalizations and longer lengths of stay (LOS) is to take a Lean approach.

Lean and Lean Six Sigma principles, a set of efficiency-focused management practices long used in manufacturing and other industries, can help a healthcare organization eliminate waste and improve quality, and outcomes. *(More information is available at: https://bit.ly/33J9e94.)*

For example, after employing Lean principles, Mid Coast-Parkview Health in Brunswick, ME, shortened patient stays of 30 or more days by more than 20%, saving $124,000.

"In 2017, we had a total of 26 patients who were here longer than 30 days, totaling 1,528 patient days," says **Cynthia Smith**, RN, BSN, CCM, nurse manager, department of case management, Mid Coast-Parkview Health. "Our chief financial officer calculated the cost to the hospital was $764,000 for care that was not reimbursed. We decided to put together a team to talk about how to better manage these patients."

> AFTER EMPLOYING LEAN PRINCIPLES, MID COAST-PARKVIEW HEALTH SHORTENED PATIENT STAYS OF 30 OR MORE DAYS BY MORE THAN 20%, SAVING $124,000.

Following Lean principles also helps

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AUTHOR: Melinda Young
AUTHOR: Jeanie Davis
EDITOR: Jill Drachenberg
EDITOR: Jonathan Springston
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS MANAGER: Amy M. Johnson, MSN, RN, CPN

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

reduce readmissions and improve care management and utilization review, says **Tami Minnier**, RN, MSN, FACHE, chief quality officer at University of Pittsburgh Medical Center (UPMC).

For instance, UPMC's utilization management process decreased time to initial authorization by 8.27 hours and lowered its cost per case reviewed, saving $834,172 per year, according to internal data.

"Care management is fraught with many process issues, and this principle and approach are key things necessary for care managers to do their jobs well and to achieve what they want," Minnier says.

The Lean principle is an easy concept to grasp, says **Barbara Ragonese**, director of quality and patient safety at Italian operations, UPMC, in Rome.

"Lean is based on the avoidance of waste," Ragonese says. "When staff's exposed to the definition of waste, including unnecessary movements and waiting times, they can easily identify areas of improvement."

Case management directors and other managers need to give employees the tools and framework to improve processes, she says. "We're doing a massive educational program on Lean in Rome," Ragonese adds. "We're testing this model."

Smith, Minnier, and Ragonese offer these suggestions for how hospitals can employ lean principles to guide quality improvement processes:

• **Create a Lean team.** Hospitals could develop a team that includes case management, the chief nursing officer, a utilization review specialist, quality improvement staff, social workers, a physician advisor, a med-surg advisor, and palliative care.

The team can meet to discuss Lean processes and changes. They can map out barriers to improving patient transitions and cutting out wasted time.

In addition to a Lean team, there can be teams created to fix specific problems. For example, an LOS team could consist of a case manager, a nurse, and a social worker. The team could develop criteria for patients at risk of a long LOS, Smith says. *(See story on reducing long LOS cases, page 136.)*

"Someone would end up on a long LOS list if they've been in the hospital for more than seven days," Smith says. "Also, any patients who don't have an acute need to be in the hospital and were issued a [payer] denial letter would be added to the list immediately."

Teams can provide consistency, Smith adds.

• **Train managers, others on Lean.** "We share a lot of this training internationally," Minnier says.

UPMC hosts a learning academy

EXECUTIVE SUMMARY

Lean Six Sigma principles and methods can help hospitals improve case management, patient care, and efficiency.

- Lean focuses on eliminating waste and can be used to improve utilization review.
- Hospitals can form Lean teams to focus on specific areas of quality improvement, such as reducing long lengths of stay.
- Brief daily huddles can help a Lean team stay on task and improve results.

with in-person and online classes. But they are not for new employees, she notes.

"We learned that trying to train people on day one about these principles is overwhelming and not value-added," Minnier says. "Not everyone needs to be an expert on Lean principles, but every employee needs to know that we value it and appreciate it."

Lean training can be performed in teams with coaches and hands-on techniques. "We believe it's best for people to learn in teams — none of us work in a silo," Minnier says. "None of us can achieve anything on our own in a healthcare environment; we need other members of a team contributing."

Doctors, nurses, social workers, and others might take Lean training, learning the basics of Lean principles. "Then, we provide them with a coach to guide them through it," Minnier says. "Working together, over time, brings more values to the student."

• Start quality improvement projects using Lean principles. Using Lean methodology, UPMC in Rome developed a quality improvement project for hand hygiene compliance, Ragonese says.

"We conducted observation to understand the real level of compliance. We found out we were at 49%, which is in line with data published by The Joint Commission," Ragonese says.

Using Lean methodology, the organization increased compliance to 80%, she says. "Of course, we're not satisfied with 80%, and we'll work more to go to a higher level of compliance," Ragonese adds. "Our purpose is to reach maximal achievable compliance."

• Hold daily huddles. Teams can hold daily huddles to discuss efforts to improve quality of care and efficiency. For example, an LOS team might meet daily for five or 10 minutes to talk about patients with long LOS and barriers to discharge. At Mid Coast-Parkview Health, the daily huddles are held in the case management office, using visual props.

"We created a visual whiteboard with a list of patients designated by the long LOS team," Smith says. "We have had times with no patients listed, but, on average, we have three to five patients on the board."

The whiteboard includes admission dates, power of attorney status, payer denials, and medical need status. "If we identify that we need the family meeting, we identify who is responsible for it and use the board as an accountability piece," Smith explains.

If a team member is asked to set up a family meeting, the board serves as a visual reminder that the meeting has to be scheduled. "The board provides a visual cue and accountability for the whole team," Smith adds.

The daily huddle also includes a quick clinical update and discussion of barriers. "It's a place where you can quickly troubleshoot any issues you might have and think about what is the task for the day," Smith says.

• Follow process improvement techniques. Organizations can employ plan, do, see, act (PDSA) methods to implement and test changes.

"We do PDSA, which is a version with plan, do, see if it works, and adapt/adopt it, and keep going," Minnier says. "We use rapid cycle change. Healthcare in the past would make a change and, in three months, think about changing it again."

Now, quality improvement changes can be implemented faster and be continuous. The goal is to start a change, stop, redo, redesign, refigure, and keep trying, Minnier says.

In the old way of making changes, a group would take months to plan solutions. Then, they would be emotionally connected to the change and ready to defend it even if it did not work, she says.

"Under PDSA, you create a plan, test it out, and if it works, keep doing it," Minnier says. "But if it doesn't work, then revise it and try something new."

The theory is to not get stuck to the first option and to not be convinced that there is only one answer to the problem, she says.

"It's about making changes until you get to the change that is right," Minnier adds. ■

Tips for Reducing Long Length of Stay Cases

By Melinda Young

Long length-of-stay (LOS) patients can cost hospitals hundreds of thousands of dollars in unreimbursed care each year.

Hospital case managers can help reduce long LOS cases through consistent care management and team support, says **Cynthia Smith**, RN, BSN, CCM, nurse manager, department of case management, at Mid Coast-Parkview Health in Brunswick, ME.

One of the many obstacles to reducing LOS is finding a patients' decision-maker, Smith notes. "You have a sick patient who does not have capacity to make a decision and who does not have a decision-maker," she explains. Therefore, it is important to reach out to friends and family as early in the stay as possible.

Long LOS patients may be alone and cannot return home safely. Some of these patients lack decision-making capacity or are unable to take care of themselves in an independent environment, Smith says. "These are the most vulnerable people that live in the community," she notes. "Some have mental illness, and some are elderly with very limited social supports and financial means."

Long LOS patients also might experience behavioral and mental health issues. They might be violent or be agitated, and some potential referral facilities will not put their staff and patients at risk by taking in these patients. "We offer psychiatry to help with determining whether patients have capacity and to help with medication management when the patient has behavioral issues or violence," Smith says. "They're part of the team, as well."

Some patients' spouses are elderly and unable to provide care because of their own chronic illnesses or dementia. "We're seeing more patients come to the hospital when their elderly spouse cannot care for them anymore," Smith says.

When appropriate, providers can make referrals to hospice care or nursing facilities. But they need someone, whether the patient, spouse, or someone else, to be the patient's decision-maker, she adds.

The lack of a decision-maker can affect the hospital's ability to collect payment for its services. For example, the patient or decision-maker must be involved with the patient's application for Medicaid or other payer resources. "It's a complicated process," Smith says. "You have to complete an application with years of financial documents and other things."

Case managers can help by setting up a meeting with the patient and family or whomever might be important in the patient's life. "We try to determine who the decision-maker is or who could be a decision-maker if the patient cannot be their own," Smith says. "We initiate a family meeting within 48 hours to assess the level of care and to make appropriate referrals." If patients have no one who can make medical decisions for them, then case managers can help the patient find a medical power of attorney.

After case managers help long LOS patients identify a decision-maker, the next step is to make appropriate referrals for the patients who do not have a medical reason for continued hospitalization.

"Realistically, we're always going to have patients who have lengths of stay more than 30 days," Smith says. "Our goal is to have fewer of these patients." ■

Transitioning Patients to Skilled Nursing Facilities Is Challenging

By Melinda Young

When hospital patients transition to a skilled nursing facility (SNF), there are hurdles that must be overcome. For example, patient information can be lost, misconstrued, or inadequate.

"Sometimes, information can get lost in translation from one facility to another," says **Claire Wueste**, LICSW, CCM, CBIS, case manager at Spaulding Rehabilitation Hospital in Boston.

Patients' expectations also can be different from what will happen next at the SNF. For instance, patients with Medicare coverage might expect that they can stay in a nursing facility over a longer period when the coverage is only for a short time, during which they must show progress. Case managers also can help patients and

families find the right SNF for their needs. *(See story on finding the right SNF, page 138.)*

"If someone has Medicare, I explain what's covered and what skilled nursing care is," Wueste says. "If someone needs a longer-term stay or has plateaued with their progress, the options are Medicaid or private pay. We have a financial counselor who can start that process here if they need that."

Wueste provides this information on how to improve the hospital-to-SNF transition:

• **Communicate well and fully.** "We do a good job of putting together a thorough discharge summary," Wueste says. "All the clinicians who work with patients perform a discharge summary."

These include physicians and therapists. They forward the document to the facility, giving SNF clinicians time to review it before meeting with patients, she adds.

Using an electronic medical record (EMR), the hospital includes specific communication and patient summaries in the notes and history that can be referred to community providers, including SNFs. "We have a good system that is used by a lot of hospitals to send information to multiple facilities at once and to have back-and-forth communication to make sure they accommodate the patient's needs," Wueste says.

Electronic communication can expedite the transition. If the SNF needs a copy of the healthcare proxy, the case manager can quickly send one. The case manager can quickly respond to any questions.

"If a patient needs quite a bit of assistance, the SNF might be concerned they'd be a long-term patient," Wueste says. "I would communicate what information I have from the family about their intentions."

For example, the patient might need to take a leave of absence from work, ask multiple family members to help, or can build a ramp to make the home discharge possible, she explains.

"We also do a warm handoff with nursing," she says. "Case managers will obtain a phone number for the nurse at the incoming facility and give a nurse-to-nurse phone call."

Case managers can give SNF staff information about the patient's pain issues and any specialized nursing concerns. "We don't do this with every case, but we've done it with the more complicated patients," Wueste says.

• **Address patients' safety needs.** "Skilled nursing facilities are able to do restraints, so we make sure they have a sense of what someone's safety needs are," Wueste says. "We have people who still might be a high risk for falling, and we want to make sure someone at the incoming facility knows this risk."

This way, the SNF can place the patient near a high-traffic area, which ensures there are people walking by who can help the patient soon after a fall, she adds. "We make sure they have a good sense of the patient's safety needs," Wueste says.

• **Provide updated therapy information.** "We never want patients to lose ground when they go to another facility," Wueste says. "Sometimes, there might be a change in terms of the frequency of therapy — slightly shorter sessions than what we do at our hospital. It could be they provide therapy three times a week instead of five times a week, so we try to be clear about what level the patient is functioning at."

Patients' families sometimes ask about the frequency of therapy at the SNF. They are considering various SNFs and want to know what will change in the person's care.

"We emphasize that the patient is there for continued rehab and will continue to benefit from continued rehabilitation," Wueste says. "The goal is to make it very clear to the facility and also to the family that we can't tell them how much therapy the patient will receive at the next facility," she adds. "But we do prepare patients and families by telling them it will be a little different than what they get here."

• **Time transitions appropriately.** "We try to time the transition to the skilled nursing facility to when it's most appropriate for the patient," Wueste says.

This timing depends on when the patient is at a level where he or she can continue to progress at a SNF and when the patient no longer needs an acute rehab level of care, she explains. "But the patient still has goals to work on," she adds.

• **Discuss insurance issues.** "Sometimes, insurers don't want to approve that level of care, even if the

EXECUTIVE SUMMARY

Too often, patient information is lost or inadequate during transitions from hospital to skilled nursing facilities (SNF). This causes challenges that case managers can help overcome.

- Write a thorough discharge summary that is forwarded to the SNF.
- Tell SNF contacts about all of patients' safety issues and concerns.
- Time the transition to when it is most appropriate for the patient.

patient has coverage for it," Wueste says. "We try to set the stage for families, telling them there will be a similar process where the facility has to get approval on a week-to-week basis. The patient will make continued gains and stay at a skilled level of care."

This is challenging. It requires a case management-style of patient advocacy — even to get the patient approved to go to a SNF, she adds. It might even require the doctor calling the payer's medical director to advocate for a SNF transition: "They might say, 'This is a patient who could go home,' and we say, 'We feel strongly they need skilled nursing facility care.'"

• **Help patients and families adjust expectations.** "Usually, I can anticipate what the questions are going to be before I make the referrals, so I try to have that information in advance and have a discussion with the family," Wueste says.

She might ask patients and families these questions:

- At what level of functioning does your loved one need to be to go home?
- Will you need home modifications? Could these start early, before the patient is transitioned to the next level of care?
- What additional information do you need?

"We develop a relationship with the family and see what they know about the longer-term plan," Wueste says. "We have a home accessibility questionnaire that therapists will give to families to get more information about their home."

The questionnaire asks about stairs, width of doorways, and bathroom measurements, such as the height of the toilet and sink. "It also has ADA recommendations in it so the family knows what the standard would be if they do have to make modifications," Wueste says. "We have the family fill it out while they're here, and give recommendations."

The goal in working with families is to be supportive, she notes. "As case managers, we develop relationships with the family," she adds. "We also coordinate families to come in and participate in therapy sessions, so they can actually see what a person is able to do, instead of just hearing it described over the phone." ■

Hospital Gives Patients Tips on Finding the Right Skilled Nursing Facility

When hospitalized patients need to be transitioned to a skilled nursing facility (SNF), one of the first hurdles is finding the right place.

Spaulding Rehabilitation Hospital in Boston has developed a one-page tool to help families with this decision. Here are a few excerpts from the tool, titled "Touring a Skilled Nursing Facility:"

• **What questions should I ask?**
- Do you have a full-time rehab (physical, occupational, and speech therapy) staff on site?
- How much therapy will I receive?
- What types of insurance do you accept?
- Is there a waitlist for admission?
- What is the average rehabilitative stay?
- Were there any issues with your recent health inspection? If so, how are you addressing them?
- What are your visitation policies?
- Is there any additional cost for services not covered by insurance, such as laundry, cable, and hairdresser?

• **What should I look for?**
- Does the facility appear to be clean, well-maintained, and free from unpleasant odors?
- Is the staff engaged with patients in a positive and respectful way?
- Do staff members greet you as you tour the building?

• **What areas should I ask to see?**
- Gym/therapy areas;
- Dining room;
- Shared areas where patients can visit with family and friends. ■

CMS 2020 Final Rules: Discharge Planning Revisions Released

By Jeanie Davis

New rules intended to help empower patients preparing to move from acute care into post-acute care will soon govern hospital discharge planning, according to the Centers for Medicare & Medicaid Services (CMS).

Under the new rules, which take effect Jan. 1, 2020, hospitals must:

- Focus on patients' care goals and treatment preferences in discharge planning;
- Assist patients in selecting a post-acute provider by sharing relevant quality performance data for those facilities, including readmission and patient fall rates;
- Ensure each patient can access an electronic version of their medical records.

"Today's rule is a huge step to providing patients with the ability to make healthcare decisions that are for them and gives them transparency into what used to be an opaque and confusing process," CMS Administrator Seema Verma said in the news release. "Patients will now no longer be an afterthought; they'll be in the driver's seat, playing an active role in their care transitions to ensure seamless coordination of care." *(The statement is available online at: https://go.cms.gov/2nG60nd.)*

Currently, the hospital case manager will prioritize patient choice in developing treatment plans, explains **Elizabeth Lamkin**, MHA, CEO of PACE Healthcare Consulting. "However, that approach has led to questions about just how much information they should provide," she explains. "Discharge planners have referred patients to home health agencies they have worked with in the past, and might include agencies operated by friends."

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires hospitals and post-acute providers to include quality scores while helping patients and families during the discharge process. The IMPACT Act was intended to encourage patients to become more active in planning their post-acute transitions. Since then, public feedback has indicated that significant policy issues must be resolved.

The Medicare Payment Advisory Commission (MedPAC) and other groups have called for more clearly defined discharge planning. Current rules that strongly emphasize patient choice have left some hospital discharge planners worried about overstepping their role, according to MedPAC.

Typically, CMS' Home Health Compare is not effective in steering patients toward the highest quality providers, according to MedPAC. The commission also has argued that CMS should give discharge planners more authority and flexibility in guiding patients toward top home health agencies.

The Case Manager's Role

"Increasingly, the hospital has responsibility for the entire episode of care. Identifying resources in the community is an important part of that process," Lamkin says. "Patient choice and providing more than just a list of post-acute providers, in my opinion, is not a new thing. Discharge planners have always had the ability to provide information on home health services. If there are higher-performing patient services available, or a provider has specialty services, the patient has a right to know that."

"CMS requires hospitals to get feedback and evaluate providers if they have a contract," Lamkin explains. "Most hospitals are now contracting with high-quality post-acute providers, and those report quality data to the hospital. The hospital should request metrics about readmissions."

The case manager can explain the services these providers offer, if they fit the patient's needs, and what quality information they have about the provider, explains **Patricia Hildebrand**, RN, MSN, executive director of Hildebrand Healthcare Consulting in Sugar Land, TX. "You can't just hand them a list to choose a provider; you have to give the patient explanations."

Discharge planners are required to inform the patient if they have a financial interest in a provider. "They may have a bias in favoring certain providers, but information on those providers should be available for all involved in the decision, including social worker and the patient, so they can make quality-based decisions," Hildebrand explains.

The big debate is which information is most useful to the patient to decide, she adds. "It's all about educating consumers. If rankings on comparing websites are not affecting patients' decisions, there may be other factors that need to be addressed." ■

Transgender Patients Face Many Challenges in the Healthcare System

By Jeanie Davis

Transgender people are becoming more open, and case managers are likely to work with patients who openly identify as transgender, explains **Michael B. Garrett**, MS, CCM, CVE, NCP, BCPA, principal with global consulting firm Mercer. "All healthcare providers should understand the terminology and how to communicate with a transgender person to establish trust," he says.

Transgender individuals are legally protected in obtaining healthcare, including transition-related care. Healthcare providers are required to treat these individuals with respect, including using their chosen gender identity. That protection exists because gender dysphoria, a behavioral health diagnosis that may be used with transgender individuals, is covered by the Mental Health Parity Act. In addition, a healthcare professional likely uses a code of ethics requiring non-discrimination based on gender identity.

That means doctors, hospitals, and insurance companies cannot discriminate against transgender patients. Some programs, like Medicare, have been slow in offering coverage, but that has changed. The Veterans Health Administration and some insurance carriers may cover some transition-related care expenses, and patients are advised to understand their coverage.

On the hospital floor, case managers must make it their mission to understand the communication nuances regarding transgender patients. "Some settings, especially academic settings, are more tuned to this," says Garrett.

Transgender people may receive healthcare services during their transition process (such as surgical procedures), yet some individuals may not undergo any surgeries or other procedures. Transgender individuals also may be admitted to hospitals for many reasons, including diabetes, cardiovascular disease, or other health issues not necessarily related to their transgender status or a transition process, Garrett explains.

"Not every transgender person will have surgery or hormones; they may just choose to dress and express as their identifying gender," he says. "Others may choose top and bottom surgery, more typical of transgender women. For transgender men, breast reduction is typical but not bottom surgery because it's not as effective."

The transgender person undergoes a process of self-awareness and confirmation of gender identity before hormones and/or surgical procedures are considered, he says. This may involve counseling or psychotherapy to assist in that process.

Healthcare professionals should be aware of this process and how to communicate respectfully. "Being

Tips for Case Managers With Transgender Patients

- Ask what preferred name and pronoun the patient uses, and consistently use that pronoun;
- Do not assume sexual orientation or gender identity;
- Mirror the language the patients use for themselves, their partners, and their bodies;
- Modify medical forms to incorporate the range of gender, gender identity, and sexual orientation. Ask those questions only when necessary;
- Do not reveal a member's gender identity or sexual orientation without permission;
- Provide referrals to healthcare professionals and facilities that provide transgender-sensitive care and expertise;
- Do not ask unnecessarily invasive questions. Make sure questions are related to the patient's healthcare;
- Educate yourself and other healthcare providers on current transgender health protocols and standards of care;
- Inquire about what transition, gender-affirming surgery, and/or hormone treatment means to the patient;
- Encourage pursuit of regular preventive care visits;
- Monitor and make appropriate referrals for behavioral health issues. ■

transgender is very different from being gay or lesbian," says Garrett. "When you are transgender, there is a discrepancy between the gender assigned at birth and the gender the person identifies with and how they express themselves, rather than who they are attracted to."

Do Not Make Assumptions

Also, hospital staff should not jump to conclusions about anyone who chooses to dress in a style that does not conform, he adds. "Just because a woman dresses like a man, or a man dresses like a woman, doesn't always mean they are transgender," Garrett explains. "The person may choose to dress as a woman but their voice is low, and there is facial hair, yet they may not identify as transgender, as incongruous as that may seem. Don't assume anything."

Some hospitals have offer development programs to acquaint staff with best practices in transgender communication. "Nurses, aides, pharmacists, every healthcare provider should be careful to use the correct pronoun, which indicates their gender identify," Garrett explains. "Gender should not be assumed. Case managers and others should ask about the identified gender identity and the preferred pronoun use. This could be male, female, gender non-binary, or some other gender identity."

Garrett provides a checklist for case managers in treating transgender patients:

- Confirm gender dysphoria (distress regarding gender identity and gender role);
- Provide information regarding options for gender identity and expression;
- Assess and discuss treatment options for coexisting mental health concerns;
- Assess eligibility, prepare, and refer for hormone therapy, if applicable;
- Assess eligibility, prepare, and refer for surgery, if applicable;
- Educate and advocate on behalf of patients within the community;

> "NEVER ASSUME ANYTHING — ALWAYS ASK WHEN YOU'RE NOT SURE. IT'S BETTER TO BE EMPATHETIC RATHER THAN ASSUME."

- Assist patients with social determinants of health in preparing a discharge plan.

In discharge planning, Garrett advises screening the transgender patient for depression and anxiety, as these patients are at higher risk. Consider their living environment and financial status as well. "If the transgender patient is young, they may have been rejected by family so they don't live in a stable household," he says.

In addition, the transgender patient should be screened for social determinants of health, such as finances (e.g., affording medication), access to transportation, and availability of food. There also may be challenges in accessing healthcare services that specialize in treating transgender patients. "All this needs to be checked out and addressed on the front end to avoid readmission," Garrett advises. Alcohol and tobacco use also is high among transgender people, he adds.

Nearly three-quarters of transgender patients have experienced some discrimination in healthcare, says Garrett. "The patient may be refused necessary care, or the providers refuse to touch the patient or they use excessive precautions," he explains. "There may have been verbal or physical abuse from providers. They may be blamed for their health status."

An estimated 20% of transgender women (male to female) are HIV-positive, he adds.

Transgender people likely have faced negative reactions elsewhere, including employment. "They're not allowed to dress in their identifying gender, not allowed to use their pronoun of choice," he says. "In some settings, there's a complete lack of knowledge about the needs of transgender people. It's especially difficult if they're going through transition, as they will change name, gender, bathroom use. Hospitals tend to have gender-neutral bathrooms, so that's not as much of an issue."

There is a high risk of incarceration among transgender people because they often have trouble getting regular employment due to discrimination, Garrett adds. There can be altercations triggered by their gender identification. Domestic violence may occur with family members or a partner. In too many cases, Garrett says, transgender people are the victims of homicide. There also is a high rate of suicide attempts (41%).

For case managers and healthcare providers, becoming attuned to trans issues is a process, Garrett explains. "Always ask when you're not sure," he says. "It's better to be empathetic rather than assume. It starts with basics in terminology; that's the crux of it. You can establish trust with transgender-friendly language." ■

Medicare Now Covers Nonskilled Home Care

By Jeanie Davis

Typically, when discharge planning involves the need for home care assistance, case managers rely on the patient's family and friends to assist with activities of daily living (ADL).

In many families, this can work just fine. But where there are odd family dynamics or if a family member is not equipped to be a caregiver, there is a need for outside help, explains **Gavin Ward**, a regional director with California-based 24 Hour Home Care.

"A lot of family members are not equipped to be caregivers, or are not comfortable with the role," Ward explains. "If the patient is their parent, they may not want to cross into the personal care — dealing with a naked parent, or incontinence care. They prefer to have a professionally trained, nonfamily member perform those tasks to maintain barriers. Or, the family member may have burnout issues."

These families could benefit from a home care agency, but the case manager may not think the family can handle the expense. "We highly recommend the case manager refer to a home care agency, even if there seems to be family support or financial support," Ward says. "Don't take it for granted they don't need it." Also, if the patient's prognosis indicates that home care may be a future need, family members should know that as well.

"Many case managers believe families can't afford nonmedical home care services," Ward says. "They believe this type of nonskilled care won't be covered by insurance, Medicare, or Medicaid."

Funding for nonmedical in-home care has been available since 1965 through the Older Americans Act, which funds Area Agencies on Aging. "This isn't 40-hours-a-week care, but could help someone just enough a couple hours a week to stay in their own home," says Ward.

The Department of Veterans Affairs offers similar programs. Groups like the Alzheimer's Association provide respite programs for primary caregivers. Medicaid waiver programs allow Medicaid dollars to fund nonmedical in-home care to help with transitional and respite care.

In 2018, CMS announced that Medicare Advantage Plans can include nonmedical home care as a supplemental benefit starting in 2019. "It's not common yet," says Ward. "CMS did not give health plans much notice to do this; they announced it in April, but plans had to submit their 2019 designs in June per CMS requirements."

Only 3% of health plans nationally have opted into the personal care benefits; 10-15% offer a respite benefit. Most health plans are taking a wait-and-see approach, as they are not ready to take on the additional risk, Ward explains. "We do anticipate during 2020-2021 seeing more plans adopting the benefit," he adds.

Identifying Reputable Home Care Services

To ensure that the referral agencies are reputable, Ward outlines the following criteria:

• **Licensing.** Some states license home care agencies; if so, ensure the agency's license is active. This can be validated through the state licensing agency; for example, California is licensed through the California Department of Social Services, Home Care Services Bureau.

• **Registries.** Often referred to as direct referral agencies (DRAs), these serve as "matchmakers" and do not employ the caregivers. Read the fine print; the liability likely will fall on the family if anything goes wrong. If the goal is to provide a full-service agency to patients and prevent the family or patient from taking on employment responsibilities, steer clear of these agencies, Ward advises.

• **Background checks.** A DRA will claim that it runs background checks, but if fingerprinting must go back the entire lifetime, says Ward, it is the best option (if available). The family should get a copy of the background and fingerprint check, which, in most states, should be an FBI and Department of Justice check going back to birth. If the agency or caregiver refuses to provide this, it is a red flag.

• **Best practices.** Refer families only to home care agencies that employ their caregivers, and provide insurance and "full service" for those caregivers. Do not refer to an agency that only provides insurance for office staff (which is a practice among registries to keep costs down). Ask for the "fidelity bond," a certificate of insurance for the caregivers. Ask what the insurance covers to ensure caregivers (not just officer staff) are covered.

"Most hospital risk management and legal departments recommend a case manager only refer to a licensed

or 'full-service' agency that employs its caregivers and provides insurance for those caregivers," says Ward. "If something goes wrong, the family will be covered — including any theft," he adds.

"It should not be difficult for a case manager to find legitimate home care agency in their area," Ward adds. "Metro areas and rural areas typically have multiple legitimate options." ■

Report Shows Potential Value of PCMH Model

Hospital leaders can make the business case for patient-centered medical homes (PCMH) by using recent research from the National Committee for Quality Assurance (NCQA) in Washington, DC.

NCQA reports that PCMH can increase annual revenue — and perhaps a great deal, depending on the payment model. Improvement measures are dependent on a practice's patient population.[1]

Milliman prepared the report for NCQA, aiming to help health systems that might be interested in leveraging PCMH to improve quality and reduce costs, says **Michael Barr**, MD, executive vice president of the NCQA Quality Measurement and Research Group. Payers increasingly are interested in value-based care, and PCMH can be an effective approach, he argues.

"The challenge to date has been that there are so many different models of reimbursement and delivery. The PCMH model is not a one-size-fits-all option," Barr says. "The question has been how a hospital leader can assess these different options and determine what makes the most sense for their organization. We wanted to look at hypothetical scenarios for how PCMH would affect a practice. The hospital leaders can take that information to make their case."

The NCQA Patient-Centered Medical Home Recognition program requires practice management processes and patient care quality metrics that address both high-cost chronic care patients and overall patient satisfaction. Currently, about 13,000 primary care physician practices have NCQA recognition.[2]

Milliman studied several models of PCMH, including the costs of implementing it and the potential benefits. "They found that in all of the different models, there would be an increase in revenue of between 2% and 20% for a hypothetical practice of 10 primary care clinicians and 20,000 unique commercial members," Barr reports. "In the early days of the PCMH efforts, there was great interest by large employers, health plans, and payers, and they offered incentives to keep it going. Some of those incentives are still around, but this paper shows that even in the absence of those incentives, practices should look closely at this model."

The report authors note that, aside from being "the right thing to do" for primary care, the PCMH model "provided organizations a clear 'roadmap' for primary care transformation. PCMH recognition was particularly helpful for those organizations that had less experience with the concepts of this advanced primary care model prior to recognition."[1]

The research should be useful in understanding the potential financial benefits from PCMH, Barr says, which will be helpful for quality professionals who support the approach because of the benefits to patient care. "If a health system is thinking about using a program that has been well studied to help improve the delivery of primary care, this model has not only been shown to improve quality but now we're seeing in these various models that you can see an increase in revenue above and beyond the cost of implementation," Barr says. "I see significant growth opportunities for primary care and transforming the way primary care is delivered." ■

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COMING IN FUTURE MONTHS

- Case management for cancer patients proves effective
- Build a case management team to improve outcomes
- Heart transplant case management can produce positive results
- Data at point of care is gaining steam

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

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CE QUESTIONS

1. **Which best describes Lean Six Sigma?**

   a. A set of management principles that is used to eliminate waste and improve quality
   b. A strategy for cutting fat from an organization's operations
   c. Philosophy of putting people first in an organization's management chart
   d. Lean = Let Employees Act Now

2. **How can hospital case managers best prepare patients for transitions to skilled nursing facilities (SNFs)?**

   a. Show families a copy of the patient's payer coverage terms.
   b. Give families a list of all SNFs in the area and highlight the ones with the best online reviews.
   c. Provide patient advocacy to help patients secure approval for transitions to SNF and explain how the patient's insurance coverage will work.
   d. Ask patients to meet with SNF office manager to explain coverage.

3. **Which is a feature of the IMPACT Act of 2014?**

   a. To promote the use of electronic health records for post-acute care patients
   b. To gather and report quality data from post-acute facilities
   c. To provide patients with star ratings for post-acute providers
   d. To ensure freedom of choice for patients

4. **Which is a best practice in providing care to transgender patients?**

   a. Assume the patient's gender by appearance.
   b. Ask the patient his or her preferred pronouns.
   c. It is unnecessary to inquire about hormone therapy.
   d. Screen for mental health conditions only if the patient asks.

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

Ethical Issues and Standards in Case Management, Part 2

Toni Cesta, PhD, RN, FAAN

Introduction

In October, we began our discussion on ethical issues of relevance to case management professionals. The principles should provide case managers with a framework when dealing with the tensions between providing quality healthcare and containing costs. However, it is doubtful that the tension can be overcome completely. Even when payers or health insurance plans make legitimate decisions, healthcare professionals may sometimes find that they cannot support these decisions in good conscience. How you respond to these dilemmas is significant in terms of maintaining ethical integrity. For example, consider the case study presented below.

HOW YOU RESPOND TO THESE ETHICAL DILEMMAS IS SIGNIFICANT IN TERMS OF MAINTAINING ETHICAL INTEGRITY.

The Problem

A 54-year-old male patient, Mr. Jameson, was taking beta-blockers for his hypertension. He went to his primary care physician, complaining of a dry cough. Mr. Jameson was diagnosed with nasal polyps, and the cough was attributed to post-nasal drip. Both Mr. Jameson's physician and the case manager believed that precipitated the need for a total systems review. However, he could not undergo these tests due to limits set by the health insurance plan. As a result, Mr. Jameson's symptoms were addressed from a cost-only approach, and a specialist denied him care.

Ethical Decision-Making Process

In this case, both Mr. Jameson's physician and his case manager confronted a conflict between their obligation to promote his best interests and their obligation to work within the cost-containment guidelines established by the insurance plan. To determine how they should have responded to this conflict, we first need to distinguish between two scenarios. In the first scenario, the insurance plan did not make a legitimate coverage decision. In other words, it failed to adhere to the principles of impartiality, publicity, and contestability.

What should Mr. Jameson's physician and his case manager do in this scenario? One option is to adopt the role of the "saboteur." Saboteurs seek to circumvent the coverage limits imposed by the insurance plan or payer by falsifying diagnoses to obtain coverage for services they think the patient needs or deserves. In general, this type of response is ethically unacceptable. It requires healthcare professionals to engage in deception, and it does nothing to improve the decision-making processes of the health insurance plan.

A better response is for Mr. Jameson's physician and case manager to press for changes to how the insurance plan makes coverage decisions. The physician should appeal the decision, thereby advocating on behalf of this patient. If more aggressive actions become necessary, they might advise Mr. Jameson to take legal action against the insurer as a way of putting external pressure on the insurer to make changes. They also may consider lobbying the insurer to establish public appeals procedures that would allow patients to challenge the coverage decisions. Finally, if the insurer is sufficiently unresponsive to making changes, they should consider limiting their involvement with the insurer as much as possible.

Even the best-intentioned insurers or payers can make coverage decisions that strike healthcare professionals as

misguided. In this case, Mr. Jameson's physician and case manager still may believe that the coverage decision was incorrect. How should they respond? Clearly, they should not engage in sabotage. The role of the saboteur is ethically questionable even when the coverage decisions are illegitimate. With legitimate decisions, it is plainly an ethical mistake to falsify diagnoses. It is deceptive, and it frustrates the legitimate financial and societal goal of containing healthcare costs.

Mr. Jameson's physician and case manager believed that a total systems review was necessary. After this was denied, they should not attempt to circumvent the insurer's legitimate decision-making procedures. Instead, they should serve as Mr. Jameson's advocate in the appeals process for denial of service. They should not argue that Mr. Jameson has a claim to all possible medical care that might reasonably be expected to benefit him; rather, they should argue either that the cost-containing policies that affect him ought to be revised or that an exception should be made to these policies in Mr. Jameson's case. If they are unsuccessful, they should explain to Mr. Jameson that they have done all they could, given the policies of their organization. They also should explain that although they disagree with the insurer's decision, they recognize that the organization has a legitimate interest in containing costs and provision of services in the most appropriate level of care or setting. Finally, if they are aware that a total systems review for Mr. Jameson would have been provided by a different insurer, they should inform him of this fact.

Acting Responsibly

As this case illustrates, the ethics of cost-containment largely involve an ability to function responsibly in an organizational setting. This requires a shift in perspective from that of an individualist who strives to do all he or she can do for the patients to that of a cooperator who strives to perform his or her role well within the organization. This shift in perspective suggests that many ethical problems that arise under utilization management procedures of health insurance plans cannot be resolved by individualistic or monological reasoning. Rather, they are problems of organizational ethics that require case managers to engage in shared decision-making — not just between the physician and patient, but also between patient care representatives, discharge planners, social workers, other providers, and hospital administrators. This highlights an important ethical role for the case manager under commercial health insurance plans. As the person responsible for coordinating the delivery of care to patients, case managers also must assume responsibility for initiating shared decision-making to resolve ethical problems.

WITH LEGITIMATE DECISIONS, IT IS PLAINLY AN ETHICAL MISTAKE TO FALSIFY DIAGNOSES. IT IS DECEPTIVE, AND IT FRUSTRATES THE LEGITIMATE FINANCIAL AND SOCIETAL GOAL OF CONTAINING HEALTHCARE COSTS.

National Association of Social Workers

The following principles are based on social work's core values of service, social justice, dignity and worth of the person, human relationships, integrity, and competence:

1. Service

Help those who are in need, address social problems, and place the interests of others above self-interest.

2. Social justice

Challenge social injustice and pursue changes on behalf of those who are vulnerable or oppressed.

3. Dignity and worth of the person

Respect a person's inherent dignity and worth. Treat everyone respectfully and in a caring manner, mindful of individual, cultural, and ethnic differences.

4. Importance of human relationships

Recognize the importance of relationships and vehicles of change. Engage people as partners in the healing process.

5. Integrity

Be trustworthy, honest, and responsible, and promote the ethical principles within organizations.

6. Competence

Practice within one's areas of competence and develop professional expertise. Strive to learn and sharpen skills and apply them in practice.

The NASW also highlights several standards of ethical social work practices, including responsibilities toward the client, colleagues, practice settings, as professionals, the social work profession, and to the broader society. *(More information is available at: https://bit.ly/2yYU7h5.)*

The Commission for Case Manager Certification

The Commission for Case Manager Certification (CCMC) identifies several values of case management practice and rules of conduct. Although these apply for those certified by CCMC, the code is applicable to the larger body of case management.

The underlying values are as follows:

1. Case management is a means for improving health, wellness, and autonomy of patients through advocacy, communication, education, identification resources, and service facilitation.

2. Recognize the dignity, worth, and rights of all people.

3. Understand and commit to quality outcomes for clients and appropriate use of resources. Empower clients in an objective and supportive way.

4. Know that everyone, including the client, his or her support systems, and the healthcare system, benefits when a client reaches optimal wellness and functioning.

5. Case management is guided by the ethical principles of autonomy, beneficence, nonmaleficence, justice, and fidelity.

The rules of conduct are listed in terms of unethical practices and as violation statements that may result in denial or sanctions from CCMC, including revocation of the individual's certification. Case managers certified through CCMC are expected to abide by these rules.

Rule 1: Intentionally falsifying an application or other documents;

Rule 2: Felony conviction;

Rule 3: Violation of the code of ethics on which the certified case manager credential is based;

Rule 4: Loss of the primary professional credential;

Rule 5: Professional misconduct;

Rule 6: Violation of the rules and regulations of the certification exam.

The CCMC code also describes several standards for ethical case management practice, including client advocacy, professional responsibility, case manager/client relationships, confidentiality, privacy, security and recordkeeping, and professional relationships. *(More information is available online at: https://bit.ly/2PcBQUc.)*

Case Management Society of America

In its 2010 Standards of Practice for Case Management, the Case Management Society of America (CMSA) emphasizes ethics as one of its standards of practice and highlights advocacy as another. It states that case managers should:

1. Practice and behave in an ethical manner. Abide by the tenets of the ethical codes underlying professional backgrounds and credentials (e.g., nursing, social work, rehabilitation counseling). Case managers may demonstrate ethical behaviors by:

a. Knowing the five ethical principles: beneficence, non-maleficence, autonomy, justice, and fidelity;

b. Recognizing that the primary obligation is to the patient/client;

c. Maintaining respectful relationships with peers, employers, and other professionals;

d. Recognizing that laws, rules, policies, insurance benefits, and regulations sometimes conflict with ethical principles. Case managers must address the conflicts to the best of their abilities and seek consultation as necessary.

2. Advocate for the client/patient at the point of healthcare service delivery, administration of health insurance benefits, and policy level. Case managers can advocate for patients by:

a. Encouraging the patient's self-determination, informed and shared decision-making, autonomy, growth, and self-advocacy;

b. Educating other healthcare professionals about respecting the patient's needs, strengths, and goals;

c. Facilitating the patient's access to healthcare services and educating the patient and family about available services;

d. Preventing and eliminating

disparities in accessing high-quality care and outcomes;

e. Expanding or establishing services and for patient-centered changes in policy;

f. Advocating for the patient when conflicts arise regarding cost-constraints and limited resources.

(Find out more about CMSA's standards at: https://bit.ly/28KokSc.)

The American Nurses Association

According to the American Nurses Association (ANA) Code of Ethics for Nurses with Interpretive Statements, case managers are expected to promote, advocate, and strive to protect the health, quality, safety, and rights of patients. The ANA explains this role with a focus on safeguarding the patient's right to privacy and confidentiality. It also emphasizes protecting patients engaged in research studies and addressing questionable healthcare and impaired practices. *(Find out more at: https://bit.ly/2ZcQIbi.)*

Other case management-related professional organizations describe case managers as patient advocates and are explicit about how they demonstrate such role expectations. For example:

• NASW, in its standard on advocacy and leadership for social work case managers, states that case managers should advocate for the rights, decisions, strengths, and needs of their clients and access to healthcare resources, supports, and services.

• The American Case Management Association (ACMA), which focuses primarily on hospital-based case managers, includes advocacy as one of its standards of practice and scope of services. It states that "advocacy is the act of supporting or recommending on behalf of patients/family/caregivers and the hospital for service access or creation, and for the protection of the patient's health, safety, and rights."

To enhance the role of advocacy and meet ethical expectations in practice, ACMA offers these guidelines:

- Determine who is the legal decision-maker, whether the patient or a surrogate;

- Share information on benefits, risks, costs, and treatment alternatives (including no treatment);

- Protect the patient's self-determination and respect care choices and wishes, including advance directives and informed decisions;

- Promote culturally competent care;

- Work with the payer/insurer to ensure that the patient accesses his or her full benefits. Negotiate exceptions when needed;

- Balance resources with patient preferences and seek expert assistance (e.g., ethics committee) to resolve conflicts and ethical dilemmas;

- Address suspected cases of abuse, neglect, or exploitation; for example, referring such cases to appropriate agencies or personnel. *(Find more information at: https://bit.ly/31CXQu8.)*

The CMSA explains in its standards that case managers educate "the client, the family or caregiver, and members of the healthcare delivery team about treatment options, community resources, insurance benefits, psychosocial concerns, case management [services], etc., so that timely and informed decisions can be made." In addition, CMSA emphasizes the importance of empowering the patient and family to solve problems and explore alternate care options to enhance the achievement of desired outcomes. These activities must be incorporated into the shared decision-making framework, especially when the case manager explains to the patient and family that they have a choice, and while they discuss options for care.

Summary

Ethics plays a large role in the work of case management professionals. Take some time to review and understand the ethical standards that apply to you and your professional area of practice so that you can protect yourself and your patients while providing the best standard of care. ■