HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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To Build a Case Management Team, Focus on Engagement

Method reduces staff turnover

By Melinda Young

Case management leaders can improve their departments by focusing on team engagement, outcomes, and developing optimal leadership.

"Case management is not for everyone," says **Pamela Andrews**, RN, MSW, MBA, assistant vice president, case management at Inova Health System in Fairfax, VA. Andrews also is the president-elect for the American Case Management Association National Board.

There is not one specific way to improve case management and develop the best teams. But a good first step is to identify team members and to focus on the correlation between their skill sets, engagement, and outcomes, Andrews explains.

> A GOOD FIRST STEP IS TO IDENTIFY TEAM MEMBERS AND TO FOCUS ON THE CORRELATION BETWEEN THEIR SKILL SETS, ENGAGEMENT, AND OUTCOMES.

After about two decades as a case management director at various hospitals, Andrews worked in population health and regulatory strategy for a managed Medicaid program before returning to leading hospital case management across five hospitals.

"We had a staff vacancy of more than 30% in the whole system," Andrews says.

Something had to change. Andrews began to investigate: "I needed to physically position myself in those

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spaces to understand the culture of the team and what kind of support and leadership was needed to build that success," she explains. "Coming into new space as a new director, you have great ideas and want to implement them. But sometimes there is a failure to pause and take the pulse of people who were never asked for help before."

The process improvement project to reduce staff turnover was successful. "We cut our vacancy rate in half," Andrews says. "We've been able to retain those new hires." In one hospital, staff increased from 93 full-time equivalents (FTEs) to 105 FTEs, she adds.

At the beginning of the improvement process, Andrews met with hospital case management directors. She learned where they were missing staff and what additional support was needed.

"I worked in each of the buildings, doing basics, including rounding, getting to know the team, looking at processes, and observing day-to-day management," she says. "I came in and talked to each team to understand where they were, and I didn't make assumptions around what I thought of where they were."

Leaders often know what needs to be done to fix organizational problems. But they make a mistake if they jump into solving issues based on their own ideas without doing their homework, Andrews notes. "I had all of these great ideas that I wanted to start working on, moving forward, but I couldn't do this because I needed to take the time to really do the groundwork and reacquaint myself with the team," she explains.

Instead, Andrews met with case management teams to find out what they thought of the current processes and what opportunities they identified.

"I had to slow down and listen to the team and get their perspective," she says. "Then, I'd say, 'Based on what you're saying and where we need to be, here are some of the elements we need to incorporate into what you're already doing, and here's how we're going to do it.'"

Andrews describes how leaders can improve case management programs, following these tips:

- **Focus on resource allocation.** "We always need more; we can't do it all," Andrews says.

Case management team discussions should center around how to size existing operations. Teams need support that might relieve their burden. For example, if a hospital is lean with limited resources, the case management leader might see where there are resources that could be reallocated.

In hospitals where there are case management vacancies, including

EXECUTIVE SUMMARY

Developing team engagement in case management departments can improve staff retention and efficiency.

- The first step is to focus on resource allocation and the size of the department.
- Case management leaders should think proactively and seek team input and collaboration in any process changes.
- Forming a case management council could help leaders obtain buy-in.

director roles, the goal might be to learn why there is staff turnover or why jobs remain vacant. If the answer is the case management staff is overworked and lacks support, a solution might be to hire case management assistants.

Another issue could be related to employees' workflow or job descriptions. For instance, some hospitals might employ case managers who perform both utilization review and discharge planning. Sometimes, these roles are difficult to reconcile within a case manager's workflow.

Case managers who have to focus on both jobs might have to spend more time on utilization review, and then find it difficult to manage patients' length of stay. The solution would be to divide the two roles, assigning some case managers to focus solely on utilization review and others on discharge planning, Andrews says.

"One person communicates with insurance companies and provides clinical evidence to validate patients' hospitalizations," she says. The other case manager provides transitional planning, offering discharge support and helping patients obtain necessary social resources, she adds.

"There is a lot of time spent with the patient, supporting a quality transition and setting up the patient to manage outside of the hospital, reducing the potential for patients being readmitted," Andrews explains.

• **Manage proactively.** Case management leaders need to anticipate potential issues and consistently watch operations, Andrews says.

Case management teams that work best often have experience together and have learned the rhythm of the group. They work within their boundaries and with the resources they have in place, she says.

Well-managed teams have better-defined priorities, so they can use resources efficiently. For example, well-managed teams will not leave gaps in case management, such as patients being admitted on Friday evenings and leaving on Sundays without ever seeing a case manager, Andrews says. One solution to this is to employ weekend case managers, shifting resources so there are fewer gaps.

Also, regulatory requirements govern communication with patients and families, and case managers need enough resources to handle these well. "Anytime you make changes, try to keep your pulse on the team," Andrews suggests. "You have to be careful in providing feedback — that's why it's so important to come in and just listen and watch."

• **Create a case management council.** "The biggest thing I did to move the needle is to form a case management council," Andrews says.

The case management council was formed by the five hospitals and their programs. Each hospital sent one to three representatives, based on the hospital's size. Representatives included discharge planning, utilization review, and administrative support/case management assistance, she says.

"We had each building vote for a representative to be part of the council and meet with me every month to review processes," she says. "They look at policies and talk about levels of engagement."

The goal was to create champions in each hospital. These were fully engaged case managers who were part of the process and ready to help the health system achieve its goals, she adds.

"We had a lot of great ideas that came from the council," Andrews says.

The council also helped solve communication problems. They would learn about new initiatives and share these with their case management teams. "This was a piece of the puzzle that helped support all of the work we were doing," Andrews says.

The meetings were phone calls at lunch time. "Because of the nature of the work, it's hard to pull them out of their buildings," Andrews says. "We decided the best way for us to successfully implement this and be consistent was to have noon calls, monthly, and always on a Thursday."

Each council member calls into a conference line. The meeting is called to order, and the members review discussions from previous meetings. "The first thing we talk about are system updates, and we ask if they have any questions," Andrews says. "I wanted them to be comfortable with asking any questions about something they heard or thought was coming or had any anxiety about."

• **Offer work-life balance options.** "We gave our utilization review people the option of working out of a home office," Andrews says. "We've been looking at things across the board, the work-life balance, which is an employee satisfier for some people."

Certain employees chose not to take advantage of the home office option, but making that choice available was a big win for the organization, she notes.

Paying attention to work-life balance shows employees that the organization is looking out for their interests and is flexible on how it defines productivity. The council debated this issue, looking at how to clearly measure productivity when employees work outside the office.

"All of those things were discussed and worked out prior to the transition," Andrews says. ■

Value-Based Care: Tips for Case Managers

By Jeanie Davis

Hospitals are struggling to meet the goals of value-based payment models. Value-based models are designed to improve outcomes, such as quality of care, satisfaction, and complications, while reducing costs. The impetus comes from CMS, which has set quality and efficiency standards for hospitals.

For decades, hospitals have worked toward these goals. "But many case managers might not realize that hospitals now face penalties if they don't meet specific benchmarks," says **Beverly Cunningham**, MS, RN, ACM, partner and consultant with Case Management Concepts.

Length of stay (LOS) and cost of care are two critical factors in the efficiency measure, she explains. Costs include both inpatient and post-discharge care costs. Hospitals are measured against benchmarks set by other hospitals across the region and nationwide, she notes.

CMS will penalize a hospital for high costs, hospital-acquired infections, ineffective discharge planning, and readmissions. For example, the CMS Hospital-Acquired Condition Penalty is a 1% reduction in payments for hospitals with lowest rates of performance — which can result in tens of thousands of lost revenue dollars over a year, Cunningham explains.

Each hospital's performance is publicly reported, which can affect the hospital's long-term financial viability. "LOS and cost per case are gauges of hospital efficiency, attracting managed care contracts and helping the hospital maintain a competitive edge," she explains.

For example, a delay in patient ambulation can lead to pneumonia, delaying discharge. The increased LOS, cost for treating the pneumonia, and hospital-acquired infection will translate into lower efficiency, leading to penalties — evidence of lower value at that hospital.

Bundling payments is another CMS method for value-based healthcare, Cunningham explains.

> "TOO OFTEN, WE PUT INTERVENTIONS IN PLACE AND DO NOT TAKE THE TIME TO REVIEW OUR OUTCOMES TO SEE IF WE ARE MAKING A DIFFERENCE."

Some bundles are mandatory, others are voluntary. "Bundling incentivizes hospitals to aim for efficiency, as the financial risk is on the hospital," says Cunningham. "This strategy also encourages collaboration across settings, and improves accountability and quality."

One example of mandatory bundling is total knee replacement. A hospital will receive a certain amount for the procedure, to be paid to physicians, skilled nursing, rehabilitation, or home care. In addition to keeping LOS and costs under control, hospitals also must use the patient's Medicare-allowed days efficiently.

Case managers can dramatically effect reaching their hospital's goals via effective care coordination, says Cunningham. All members of the patient care team must collaborate to drive efficiency.

In addition, case management leaders must take steps to stay connected with hospital executives to know the trends in their hospitals, she adds. "If you don't know, you can't make any strategic decisions on improvements."

Understand All Facets

Case management leaders can make it a priority to learn all facets of this value-based initiative, Cunningham says. They can assist each staff member in identifying interventions that can positively affect the value-based outcomes of their specific patient group.

- **Assess patients carefully.** Identify social determinants of health that may create barriers in discharging patients and implement solutions to remove those barriers that may increase LOS, increase cost per case, increase risk of readmission, and increase avoidable days.
- **Focus on the hospital's areas of risk.** For example, if a hospital has established bundled payment patient groups, monitor and report cost per case, length of stay, readmissions, and avoidable days.

For example, a cardiac group must be monitored and the results reported, including any trends to the case management staff involved with cardiac patients. The case management leader must assist both RN case managers and social work case managers in building interventions that can positively affect those outcomes.

• **Share outcomes with appropriate physician groups, and identify how the case management staff can collaborate with them to improve those outcomes.** This process applies to all patient groups where the case manager can improve the patient's care, Cunningham advises.

• **Work with discharge facilities and services.** Strive to transition patients to providers with fewest readmissions and complications of care, such as rehabilitation, long-term acute care, home care, or skilled nursing facilities.

"With the latest CMS final rule for discharge planning, we must involve the patient in their post-acute care decisions and provide them with providers that have the best outcomes," she explains. "At the same time, we still have the obligation to allow choice. The final rule sets the scene for assisting the patient in making a more informed choice."

Ensure their processes also are aimed at efficiency. "We must have people in post-acute settings who are aligned with our goals and working with us," she adds.

Cunningham advises meeting with these post-acute resources regularly to discuss outcomes and reinforce the hospital's mission of efficiency. "You want them to know how serious you are about this," she says. Post-acute providers will be serious about their outcomes, as they also are in the process of transitioning to value-based payment.

• **Track avoidable days.** For example, if physical therapy is not available on weekends, track and report the delays. "When the case manager in each area reports their avoidable days, the aggregate can be very impressive," says Cunningham. "This can result in the physical therapy department re-evaluating how they schedule their staff on the weekends." Those delays can occur on a medical-surgical unit, orthopedic unit, cardiac unit, or surgical unit.

Also, if nursing is not ambulating noncomplicated patients, but depending on physical therapy, this should be addressed. "Nursing must understand how this delay in ambulation affects overall length of stay," she explains.

• **Track outcomes of interventions.** "Too often, we put interventions in place and do not take the time to review our outcomes to see if we are making a difference," says Cunningham. Discuss interventions with supervisors and ask for monthly outcome results to understand the effects of the interventions.

"Case management staff must understand the impact their interventions have on value-based reimbursement by seeing the trends (positive, negative, or flat) from their daily interventions," says Cunningham. "This includes RN case managers and social work case managers."

If not, they are just guessing about the effects of their interventions, she explains. "For too long, we have assumed that just because we do something, it yields positive results. That is not true." ■

'Person-Centered' vs. 'Patient-Centered' Care

By Jeanie Davis

Long-term support services should provide "person-centered care," according to a 2014 rule from CMS.

In everyday patient care, this translates into a focus on learning a patient's wants and needs, which helps the case manager align treatment with the patient's desires, explains **Susan Fegen**, LVN, manager of person-centered programs and complex care management at Centene Corporation. She is a certified mentor-trainer for The Learning Community for Person Centered Practices (TLCPCP). Her mission is to integrate the nuances of person-centered care into hospital-based programs that emphasize patient-centered care.

Fegen sits on the National Quality Forum Committee for Person-Centered Planning, which is working to define the concept in terms of person-centered thinking, planning, and practices. The committee has designed a set of core competencies and recommendations to support person-centered practices across the nation.

Their draft of a CMS rule change for the definition of Person Centered Planning was released for public comment on Nov. 1, and the final changes will be available in June 2020.

The purpose, says Fegen, is to give people dignity to manage their own lives and to establish measures to improve person-centered healthcare. "Patients are people who should be allowed to make their own decisions and have their rights respected, including their right to take risks in healthcare, so they have control over their own lives," she explains. "In

hospitals, patients are too often told what to do, with little consideration given to their own wishes. Healthcare providers are focused on helping people achieve better outcomes for health and safety, but that's not always the patient's focus."

She offers an example. "If I learned I had cancer, and was told I needed chemotherapy, I would tell you 'No.' Would you bother to ask why, or would you just write 'noncompliant'? We often take it as adverse behavior without taking time to listen, understand, and support the patient to maintain their dignity and how they want their life to be," she explains. "I want you to understand I have choice over my body, and I am not unreasonable, but I would like to research all forms of treatment before I make a decision."

A treatment plan should not be developed without a conversation with the patient, says Fegen. "We need the patient's input."

To ensure true success in treatment for any patient, providers need to understand that the patient must want the treatment. "It must fit in their lives and support their priorities," she explains.

A nurse learns to develop a care plan that focuses on health and safety goals for the patient. "But what about the things they value in their lives? We've rarely addressed those components, and yet that's what drives a person to make decisions that affect adherence," says Fegen. "We have to learn more about the patient's priorities to help them make the right decisions for their health."

For example, a patient with diabetes who is noncompliant in blood sugar management. "This person may have already had limbs amputated, so why are they not managing their blood sugar?" asks Fegen. "Often, it's because other things take priority. It might be very simple; they might be taking care of a grandchild, and provide meals for that child, but that leaves them with insufficient funds for medications," she adds. The patient may ration his or her medications, because it is more important to them to support their family.

"We have to identify factors that are important to each person, and we have to start asking why," says Fegen. "That's how we can create a holistic care plan that supports their health, and ultimately supports what they want in their life. With that question, you show you understand what's important to the person, so you can then tailor their goals and interventions to reach those outcomes."

This approach empowers people to take control of their lives again, says Fegen. "Most of this falls into 'informed decision-making,' where I understand all my choices, outcomes, and possible consequences of the choices I make."

She advocates starting this process at patient admission. "We should create a description of who the patient is, what they like, and their preferences," she explains. "In all our interactions, we should respect who they are, respond to them the way they choose."

When additional information is gathered during the patient's hospitalization, this should make discharge planning more efficient, she adds. "We will know their support systems, whether they have family, friends, and know the community resources they will need," Fegen explains. "We can arrange for paid resources, if applicable, so their discharge is more successful with less risk of readmission."

She adds, "If a person goes home with a plan they want, they are more likely to work toward their goals and self-manage their care."

When getting to know patients, Fegen advises using the basic concept of person-centered thinking as a starting point:

What is important to the patient?

- Relationships;
- The way they want to live;
- Activities they enjoy;
- Things they want;
- Status and/or control over their lives.

What is important for the patient?

- Physical and mental health;
- Safe living environment, well-being, protection from abuse, neglect, or exploitation;

• A sense of purpose;

• Being valued for contributions to community.

If there is a balance between "important to/for":

• Is the patient's support focused only on health and safety?

• Is it heavily based on their wants, with no regard to health/safety?

Other important issues:

• What the patient wants to learn/what they need to learn;

• What the patient needs to stay the same in their life;

• What the patient needs to change.

Fegen also is assisting with a study of person-centered practices, in collaboration with TLCPCP. "Person-centered thinking has been around since the 1970s, originally starting with clinical behavioral health. Over the years, it has morphed into a concept that works for humans, and is being adapted to healthcare," she says. "Studies of the concept have been difficult because it's very subjective, but we want to capture outcomes."

"Typically, in healthcare, we focus on what is right or good for the patient, but we can easily lose sight of the person at the center of that care plan," says **Vivian Campagna**, MSN, RN-BC, CCM, chief industry relations officer for the Commission for Case Manager Certification. "As healthcare providers, we absolutely need to consider what are the person's values, wants, desires, and goals because without understanding those, we can't put a plan in place to achieve them. It's important to remember that their goals may not coincide with ours, but that doesn't mean that they're wrong."

When providers impose goals on patients, they are not likely to achieve them, she adds. "Before we start treatment, it behooves us to consider, and respect, the person at the center of everything we do. We'll be better providers because there will be better adherence to the plan that the person has helped us design." ■

Hospital Collaborates With EMS to Bring Case Management to Homes

By Melinda Young

An Ohio hospital's population included people with lower income, less education, and many health challenges. Case management could help once these people entered the hospital, but the challenge was to prevent the problems that first led to ED visits and rehospitalizations.

"We felt we needed to engage community partners to help us improve our quality outcomes," says **Joe Geskey**, DO, MBA, MS-PopH, vice president of medical affairs at OhioHealth Doctors Hospital in Columbus.

Geskey heard about a possible solution: EMS and fire department in one of the hospital's areas already were performing community outreach.

A recent study of the hospital-EMS case management program demonstrated success. Patients in the program experienced a 44% drop in 30-day ED visits and a 28.4% decline in 30-day readmissions. The program also was cost-effective for the hospital, providing a $3,626 profit, compared with a loss of $9,915 for a control group.[1]

"I had the opportunity to meet the Norwich Township EMS provider, which had this very engaging model of being invested in the community and doing home visits for local citizens," Geskey explains. "We decided to collaborate with our case management department here at Doctors Hospital and use some of the data we had already collected in our electronic medical record [EMR]."

The Norwich Township Fire Department in Hilliard, OH, had been providing paramedical services to its population for about four years. The program is called Focus Hilliard, and it includes a contract social worker, says Battalion Chief **Chris Grile**.

"Until we started this collaboration with Doctors Hospital, the way we started was through self-referrals from emergency calls," Grile says. "Someone would call 911, and one of our staff would identify needs that were not necessarily correct for the emergency room, and identify other needs that needed to be met."

Doctors Hospital's plan was to create a list of inpatients who resided in Norwich Township, and approach them about the EMS service.

"We created a brochure and had case managers visit the patient and say, 'You're eligible for a service for EMS to see you at the hospital to make sure that you stay safe and well before you see your primary care physician,'" Geskey says.

A small group of firefighter paramedics visit people to assist with their needs. It might be to assess their home for fall risks, check on their

access to medication or medication storage, or to sit and talk with people who are older and homebound and need someone to check on them, regularly, Grile says.

The Focus Hilliard program does not overlap with emergency services. If a person needs emergency medical care, the patient is transported to the hospital, he adds.

Here is how to create a hospital-EMS case management collaboration:

• **Make a case for paramedicine.** The study of the Norwich Township paramedicine program showed that hospitals benefit both financially and in quality outcomes from a collaboration with local EMS. However, there is a net cost to EMS: The study found that the intervention cost to EMS was $1,937. Hospitals could make these collaborations feasible through providing grants to fire departments to help offset the EMS costs.

A chief benefit to partnering with EMS is that it helps these community first responders continue to help their populations, even as the rate of fires and 911 emergencies drop. "This program gives us the ability to reduce risk in our community," Grile notes. "The program gives us access to people we might only interact with through 911 calls of service."

It has opened a new avenue of community engagement: "The more folks we can bring to Focus Hilliard, the greater number of people we can keep healthy and safe at home," Grile says.

• **Identify candidates for program.** Doctors Hospital used risk modeling, based in EMR data, to gauge severity of illness and to assess how likely patients were to return to the ED or be readmitted to the hospital, Geskey says. "We tried to tailor interventions for people who had a high risk of coming back into the hospital unexpectedly," he adds.

• **Make referrals.** Hospital case managers connected with the Focus Hilliard social worker to make referrals from the hospital's list of eligible patients.

"Case managers go through the list and call Norwich," Geskey says. "We give patients a brochure about the service." Doctors Hospital also recruited patients to participate in a study of the hospital-EMS case management project.

• **Find the right paramedics.** "In my opinion, firefighter paramedics are the right people to do this work," Grile says. "We have the respect and trust of the community and local jurisdictions."

Firefighter paramedics are every community's go-to people in the event of emergencies. "Whether a house is on fire or the basement is flooding, when you call 911, you get the fire department," he explains. "Over generations, these are the people who come to your house when you need help."

Firefighter paramedics form relationships with communities through this type of program, says **Heith Good,** firefighter paramedic for Norwich Township Fire Department. "We do our job in a far different way than taking someone who calls 911 to the hospital," Good says. "We are problem-solving for people and taking care of their needs in a more intentional, relational way."

They develop relationships and build trust with patients. "That was the excitement for us — walking away at the end of the day and saying we truly made a difference in their lives," Good says.

"We solved a problem and met a need," he adds. "At the end of the day for a firefighter paramedic, there's a lot of value for that." ■

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Strategic Program Shortens Urban Hospital's Length of Stay

By Jeanie Davis

As urban hospitals grapple with length of stay (LOS) penalties, they must help their patients solve everyday problems. Lack of resources is a fact of life for inner city residents, and hospitals need to find a way to help those patients overcome those obstacles — and reduce LOS.

In 2019, **Vitrea Singleton**, RN, MSN, CCM, joined South Pointe Hospital, an urban hospital on the edge of Cleveland, as the manager of care management — and inherited the hospital's LOS problems. Some issues were internal, involving delays in hospital processes. Others were inherent in an underserved population. "Some patients stay extra days because their caregiver can't get off work, they can't get a ride, or

they didn't have anyone to help with home care," she says. "We constantly dealt with those types of challenges."

The hospital nurses and social workers held daily meetings to plan patient discharges. However, Singleton found that C-suite support could be helpful in "pulling strings" to get patients the help they needed.

She initiated a plan to transform the daily meetings, turning them into strategy sessions with the goal "to enhance patient experience, achieve the best patient outcomes, and reduce overall healthcare costs," she explains.

The case management team includes Singleton, eight nurses, and six social workers. In August, they conducted a hospitalwide needs assessment to identify processes to reduce LOS.

First, the team improved the patient intake process, using a comprehensive assessment form that helped better identify the patient's needs and potential barriers in discharge planning. "Learning the barriers very early helps us get ahead of the problems and address them," she says.

The team also identified key points that affected LOS. This primarily involved delays in insurance approvals, scheduling, and patient transportation. They found that patients hospitalized for observation were held up to 40 hours (the goal is now 30 hours) because of scheduling delays for diagnostic and surgical procedures.

The daily team meetings have evolved over time, Singleton reports. "They have become more in-depth every time, a more collaborative effort, and the executive team has become much more involved," she explains. "I think they've learned the process is not as easy as it looks. They've gotten involved in handling certain barriers, and prioritizing changes to improve scheduling and insurance approvals."

The executive team also has pulled strings to find subsidized home care for patients, a significant move in reducing LOS. Whereas LOS has been reduced to 4.5 days, she expects the hospital to reach its 4.2 goal by January. "We keep hammering away at the goal," she says.

Because the initial patient assessment is comprehensive, the team anticipates the patient's needs long before discharge, Singleton adds. "We also anticipate the barriers and risks, and develop Plan A, Plan B, and Plan C accordingly."

This early planning allows the team to obtain insurance approvals and make early referrals on the patient's behalf; for example, to identify the viable home care options. Adding a nurse practitioner to assist with discharge planning has helped solidify the plan and prevent readmissions, she adds.

These improvements "will help the hospital avoid CMS penalties and achieve a competitive advantage, able to attract improved technology and high-quality healthcare providers," says Singleton.

Singleton believes that a case manager is most effective in a management position, as this brings greater access to the C-suite — which helps get things done. She advises nurses to pursue a master's degree to improve their leverage in their hospital system.

Singleton has adopted the role of project manager with the discharge planning team to focus members on identifying problems, then setting and achieving goals toward improvement. "We want to be a model of achievement in our hospital," she says. "We want to show others that changes can be made fairly quickly and effectively."

Toni Cesta, PhD, RN, FAAN, partner and consultant with Case Management Concepts, LLC, puts this in perspective: "Managing length of stay is a multifactorial process that includes internal hospital delays as well as delays outside the walls of the hospital," she says. "Some of these delays are correctable if identified and dealt with early."

Identifying patterns of delay, rather than using each delay as a one-off, is most important, she adds. Typically, the categories include internal system delays, external system delays, patient, family, legal, provider, and others.

"Case managers have an obligation to perform three functions as it relates to avoidable delays," explains Cesta. "First, identify them in real time. Secondly, work to correct them in real time. Finally, enter them into a database so that patterns and trends can be identified for corrective action."

An interdisciplinary team often is key to reducing occurrence rate, so choose those delays that provide the biggest return, she adds.

Also critical: identifying those delays that are most easily correctable. "This is a key role for hospital case managers, but sometimes underperformed due to staffing or other time constraints."

Avoidable delay management should be part of the case manager's daily workflow, Cesta explains. This will foster a more comprehensive approach to LOS management as it focuses beyond discharge planning delays.

"As your department begins to chip away at these delays, the overall throughput of your patients will be improved, and LOS will improve as well," she adds. ■

Technology Solutions for Diabetes Care Management Vary in Effectiveness

By Melinda Young

Diabetes care is better informed than ever before, yet overall glucose control has not improved as expected. Research suggests the problem is related to engagement — convincing patients to improve their health actions between their quarterly doctor visits.[1]

Investigators recently studied technological solutions to improve diabetes patients' engagement. They found multiple digital diabetes management systems that could help. These solutions include smartphone apps, devices with built-in connectivity, and coaching and support provided remotely through human or automated connections.[1]

"One of the biggest gaps, despite all of these new medications and treatments over the past decade, is that blood sugar control of people with diabetes has not really improved very much," says **Robert A. Gabbay**, MD, PhD, chief medical officer at Joslin Diabetes Center in Boston.

The gap is in the time between appointments. The doctor might educate the patient about how to manage diet, exercise, and medication, but with no follow-up for several months, the patient might not maintain optimal adherence. "We need to do something different," he says. "The biggest promise of these solutions is to help patients between visits."

Case management can provide patient engagement between visits. There also are technological ways to remind patients to stay on the right path and to keep them engaged in their own progress. Most providers and patients are unaware of technology solutions to diabetes care, and they do not know how to find the best option, Gabbay notes.

The study on digital diabetes management systems was designed to give providers some idea of what solutions exist and how they compare in design and outcomes. A chief feature among the solutions involves coaching on healthy behaviors, Gabbay says.

"The different approaches out there vary from ones that are completely automated and don't require humans at all, providing text messaging and other things, to some combination of texting with personal conversations that help people problem-solve," he explains.

Coaching technology helps patients track their food intake, exercise, medication use, sleep, and stress levels.

"It provides reminders to people and makes a series of healthy suggestions to keep people on track," Gabbay says. "Typically, someone will set a goal — 'I'm going to cut down on hamburgers' — and the technology reminds the patient of that goal."

The technology can reinforce positive behavior by sending messages, such as "You didn't eat any hamburgers today. Great! And let's work on that tomorrow," he adds.

Many of the technological solutions are part of an overall case management plan, he notes. "They differ in how much they use that and how advanced those skill sets for those people are," Gabbay says. "They could have health coaches, diabetes educators, physicians, or endocrinologists."

While the technology solutions vary, many patients realize that having some personal piece is helpful, he adds.

The study outlines a variety of attributes diabetes technology solutions provide, including:

- Managing health conditions;
- Providing peer support interactions;
- Prescribing providers on the care team;
- Connecting through medical devices and continuous glucose monitors;
- Treatment personalization;
- Demonstrating clinical and real-world evidence.

Increasingly, healthcare payers are aware of digital diabetes management systems, but patients and providers are less informed, Gabbay says. "The number of patients involved with the technology still is very small when compared with the overall burden of diabetes," he says.

"Payers are slowly covering these kinds of things. As that happens, it will make these solutions more available," Gabbay adds. "From the payers' perspective, they want data to show it's effective before they pay for it."

Many technological solutions to diabetes control are in the early stages of development. It is a quickly evolving field, Gabbay says. "But there clearly are data showing these are effective," he adds. ■

REFERENCE

1. Levine BJ, Close KL, Gabbay RA. Reviewing U.S. connected diabetes care: The newest member of the team. *Diabetes Technol Ther* 2019; Oct 3. doi: 10.1089/dia.2019.0273. [Epub ahead of print].

CMS 2020 Final Rules: Inpatient and Long-Term Acute Care

By Jeanie Davis

Antimicrobial resistance represents a serious risk for Medicare beneficiaries and the general public. CMS is finalizing an alternative new technology add-on payment pathway for antimicrobial products designated by FDA as Qualified Infectious Disease Products (QIDPs).

Similar to the alternative pathway for certain breakthrough devices, under this policy, a QIDP will be considered new and will not need to demonstrate that it meets the substantial clinical improvement criterion; it will only need to meet the cost criterion. CMS also is increasing the new technology add-on payment to 75% for an antimicrobial designated by the FDA as a QIDP.

Also, CMS is implementing broader changes to the Medicare Severity-Diagnosis Related Group (MS-DRG) severity level designation overall. Under this change, those antimicrobial drug resistance ICD-10 diagnosis codes will be designated as a complication or comorbidity — which generally results in a higher severity MS-DRG due to the greater resources associated with diagnoses with such designation.

This ruling "places additional emphasis on patients with serious infections like sepsis," explains **Susan Wallace**, MEd, vice president of inpatient services with Administrative Consultant Service in Shawnee, OK.

"The changes regarding diagnosis codes indicate that a patient's resistance to certain antibiotics will be considered an important secondary diagnosis," says Wallace. "That allows the hospital to be eligible for additional reimbursement to cover the patient's care. It's also an incentive for hospitals to make sure the physician documents a patient's drug resistance."

Antibiotics for these serious infections are expensive, and wound care involving resistant bacteria is high level, Wallace explains. "This change is important for hospitals that are not getting reimbursed for the care they're giving. It goes back to documentation, coding and billing capturing every detail of the care that was given."

It is important for case managers to access and understand these payment details, Wallace says. "When you're following patients through the course of care, you need to communicate with the physician about their clinical documentation as well as the entire team so everything is included in the documentation."

Coding Secondary Diagnoses

In coding secondary diagnoses, the big news is what did not happen, says Wallace. In this year's proposed rule, CMS promised to make changes in classification of more than 1,500 secondary diagnoses. "This would have had a drastic impact on hospital reporting and reimbursement," she explains. "But they decided not to make any of those changes this year. That's huge. We were very surprised that they rescinded those changes in the final rule."

An important caveat: CMS has not completely shelved the action. "They needed to evaluate the data and decide how to roll out changes," says Wallace. "It's still important to keep an eye on it. I think they decided it was too much to change at one time, so the changes may be incremental."

Overall, the impending changes in coding emphasize the need for case managers to work closely with physicians on documentation in the medical record so that it tells the whole story of the patient's illness. "Every year, we see CMS is making decisions based on data submitted in previous years, and it continues to raise the need for documentation to be as accurate and complete as possible," says Wallace.

"This is an ongoing process," she explains, "because every time we get new codes, CMS evaluates them and makes adjustments to diagnostic-related groups based on what they're seeing in actual practice." ■

COMING IN FUTURE MONTHS

- Wearable technology can deliver effective case management
- Researchers identify better strategy for reducing ED visits
- Study authors note trend about hospital readmissions
- How case managers can participate in public policy advocacy

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

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CE QUESTIONS

1. **Which is an aspect of person-centered care, according to Susan Fegen, LVN?**

   a. Identifying what is important to the patient
   b. Imposing a care plan on the patient
   c. Telling the patient that taking medications is the top priority
   d. Informing the patient what is best for him or her

2. **In which way can case managers positively effect in value-based care, according to Beverly Cunningham, MS, RN, ACM?**

   a. Moving patients quickly through the episode of care
   b. Learning and understanding all facets of value-based care initiatives
   c. Using a hands-off approach to helping patients decide on post-acute care
   d. Leaving it to others to communicate with hospital executives

3. **In a study of a paramedicine case management collaboration between OhioHealth Doctors Hospital and the Norwich Township Fire Department, how much was the program able to reduce 30-day ED visits?**

   a. 18%
   b. 24%
   c. 44%
   d. 60%

4. **New technology used to help with case management of diabetes patients includes which potential health solution?**

   a. Sounding an alarm when it is time for a patient to stand from a sitting or lying down position
   b. Coaching on healthy behaviors
   c. Setting healthy eating quiz schedules
   d. Giving patients emoji gifts when they answer questions correctly

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

The Case Manager's Toolbox: The Essential Skills of an Effective Case Manager, Part 1

By Toni Cesta, PhD, RN, FAAN

As RN case managers and social workers, you are key advocates in the delivery of quality healthcare. Your broad skills and training allow you to assess patients' needs and to work well with families and other members of the healthcare team. Negotiating, collaborating, communicating, team-building, precepting, educating, and consulting are the basis of what a successful case manager brings to the care setting each day. There are skill sets every case manager and social worker needs to be effective. These skills form the foundation of an effective case management professional.

Case management is a collaborative process used to assess, plan, implement, coordinate, monitor, and evaluate options and services to meet individuals' health needs through communication and available resources to promote quality, cost-effective outcomes.

The RN case manager's expertise is the vital link between the individual, the provider, the payer, and the community. Successful outcomes cannot be achieved without using specialized skills and knowledge applied through the case management process. Not everyone possesses the necessary skills to become a successful case manager. Case managers and social workers need to be clinically astute and competent in their areas of practice. It is important for case managers to be skilled in the case management process and to learn the assessment skills that make them better able to identify the patient's actual and potential health problems. This allows them to implement the required interventions to successfully resolve these problems and to evaluate the outcomes of care and responses to treatments.

SUCCESSFUL OUTCOMES CANNOT BE ACHIEVED WITHOUT USING SPECIALIZED SKILLS AND KNOWLEDGE APPLIED THROUGH THE CASE MANAGEMENT PROCESS.

Assessment

Assessment is an ongoing and continuous process occurring with all patient/case manager/social worker interactions. It is during the assessment phase that the case manager seeks a better understanding of the patient, the family dynamics, and healthcare beliefs or myths. Generally, an assessment involves three phases: gathering data, evaluating data, and determining an appropriate plan. Case managers use a multifaceted subgroup of skills to accurately assess a patient's needs:

Case Management Process

1. Assessment;
2. Planning;
3. Implementation;
4. Coordination;
5. Evaluation.

Leadership Skills

1. Patient advocate;
2. Facilitator;
3. Negotiator;
4. Quality improvement coordinator;
5. Resource manager;
6. Educator;
7. Financial analyst;
8. Decision-maker;
9. Critical thinker;
10. Data manager and analyst.

Communication/Interpersonal Skills

1. Team-building;
2. Customer relations;
3. Public speaking;
4. Conflict resolution;
5. Delegation;

6. Information-sharing;
7. Systems thinking;
8. Emotional intelligence.

As an assessor, the case manager must obtain relevant data through thorough investigation. All information related to the current plan must be evaluated with a critical eye to objectively identify trends, set and reset realistic goals, and seek viable alternatives when necessary. A vital case management skill is the ability to recognize a patient's health problems and formulate action plans based on the subjective and objective data collected during the assessment. The diagnoses express the case manager's judgment of the patient's clinical condition, functional abilities, responses to treatments, healthcare needs, psychosocial supports, financial status, and post-discharge needs.

Planning

Planning is the next step in managing the patient's care. Case managers plan the treatment modalities and interventions necessary for meeting the needs of the patient and family. During the planning phase, the case manager, in collaboration with the other members of the healthcare team, determines the goals of treatment and the projected length of stay and, immediately on admission, initiates the transition plan. Determining goals is vital because it provides a clear time frame for accomplishing care activities. Case managers must identify immediate, short-, and long-term needs, as well as where and how these needs will be met.

Planning is initiated on admission or, when possible, before admission. Data are assimilated, plans established, and an interdisciplinary plan of care unfolds.

Throughout the acute hospital, subacute, home care, or long-term care stay, the case manager monitors and re-evaluates the plan for accuracy as the patient's condition changes. As a planner, the case manager identifies a treatment plan while remaining cognizant of the patient outcomes and minimization of unnecessary costs. The case manager must include the patient and family in decision-making, and consider the patient's goals as an integral part of the care plan. Alternate plans always must be incorporated in anticipation of sudden shifts in the treatment process or in response to treatments yielding complications.

Implementation and Coordination

Implementation and coordination involve building the plan, determining the goals of care, and deciding what needs to be accomplished to create a viable and realistic plan. The case manager's goal is to give the patient and family the knowledge, attitudes, and skills necessary for the implementation of the plan. Through communication, collaboration, and teaching, the case manager works with the interdisciplinary team to motivate the patient to succeed in meeting the goals of care.

As the patient nears discharge, the case manager can take three steps to improve the chances of effective plan implementation: clarifying the transfer of responsibilities of care, reviewing the plan to ensure that nothing has been overlooked, and making last-minute alterations and arrangements for the immediate discharge period.

Evaluation

The final step in the case management process is designed to measure the patient's response to the care plan, and ensure the appropriateness of the plan and the quality of the services and products offered.

To achieve successful evaluation and outcomes, the case manager must routinely assess and reassess the patient's status and progress toward reaching the goals set forth in the plan of care. If the situation is stalled or regressing, the case manager must alter the plan accordingly.

The following important questions must be considered as the evaluation proceeds:

- Were the patient's needs identified early in the hospital stay?
- Were learning goals identified and teaching documented?
- Were referrals complete and timely?

The Importance of Confirming the Plan

Taking the time to confirm the plan increases the plan's effectiveness. Follow-through will help ensure that the goals are met.

- Could the patient/family clearly verbalize the goals of the care plan?
- Were the patient's/family's problems resolved?
- Was the patient/family satisfied with the plan and the decisions surrounding the plan?
- Did the patient/family comply with medical advice and follow the case manager's recommendations?

• Were the services provided appropriately and authorized by the managed care organization?

These questions will help the case manager determine if the discharge plan was effective, and will assist with quality improvement efforts for future patients.

Leadership Skills and Functions

The case manager must use many leadership skills to effectively master the case management process. Because case managers function as problem-solvers, resource managers, and members of the interdisciplinary healthcare team, they should be highly skilled in various leadership qualities. Nurse case managers and social workers must be adept at negotiating, making sound decisions, and resolving conflicts. To perform this successfully, you must use critical thinking and problem-solving skills.

Advocacy and Facilitation of Care

Patient advocacy is one of the most critical elements of the case manager's and social worker's role. The patient-case manager relationship is built on trust, to foster mutual respect, and to establish a rapport that facilitates communication among the family, caregivers, payers, and other healthcare team members. As case managers gain a clearer understanding of the patient's needs and goals, they communicate this understanding to the members of the healthcare team. They also can alter the course of treatment for early discharge or arrange for more efficient home care services. The case manager can be a catalyst for change by empowering the patient or family members to seek solutions throughout the acute care phase and beyond the hospital setting.

Case managers and social workers can best advocate for patients and their families if they apply these techniques:

• Keeping the patient's best interest paramount in the process of care delivery;

• Recommending, coordinating, and facilitating the most effective plan of care;

• Protecting the rights of patients;

• Communicating to other providers and documenting the patient's care preferences;

• Facilitating the patient's and family's decision-making activities by keeping them well informed of their rights and options;

• Clarifying the goals of therapy and treatment;

• Determining the appropriateness of the post-discharge services and the discharge/transitional plan;

• Ensuring the interventions are consistent with the patient's needs and goals of treatment;

• Maintaining the patient's privacy and confidentiality;

• Negotiating on behalf of the patient/family with the managed care organization for service authorizations;

• Facilitating resolution of ethical conflicts;

• Maintaining current knowledge of the legal and ethical requirements and standards of patient care delivery;

• Preventing delays and variances in care delivery.

Clinical Reasoning and Critical Thinking

In case management, problems involving the patient, family, and healthcare provider continuously arise. It is important that case managers solve these problems. The case manager's ability to provide safe, efficient, and competent services depends heavily on their skills in problem-solving, clinical reasoning, and critical thinking. These skills have one thing in common: They all entail generating solutions to problems, issues, or concerns regarding patient care delivery and options.

Case managers use their clinical knowledge, expertise, and leadership skills. They capitalize on their role as informal leaders of the healthcare

team and facilitators of patient care delivery to solve the problems that may arise.

Case managers assess the patient's and family's current state and, based on this assessment, envision the outcome by deciding the goals and expected outcomes of the treatments. They implement an action plan to bring the patient and family to the desired outcome. This framework enhances an outcomes-based approach to the delivery of case management services. Usually, the plan is interdisciplinary and implemented only after approval of the healthcare team and consent of the patient and family. Case managers constantly reassess, monitor, evaluate, and revise the plan until the desired outcomes are achieved.

The case manager's skills in decision-making, clinical reasoning, and judgment must always help the patient to work through the confusion he or she faces in the complex healthcare environment. Case managers answer questions pertinent to the development of the care plan, delivery of care, and evaluation of the discharge plan, such as these:

- Is the current treatment plan appropriate to resolve the patient's problems?
- Will the case management action plan prevent readmission?
- Are these the best possible treatments for the patient and family?
- Are healthcare team members in agreement with the plan?
- Has the patient or family expressed any disagreements with the plan?
- Should any changes be made to the plan of care or the discharge plan?
- Will the electricity in the home support a mechanical ventilator?
- Does the patient have safe access to a bathroom on the main floor of the house?
- Is it worth the hospital's financial support to fly a patient out of state rather than incur the cost of an extended length of stay?
- Is the family capable of learning how to perform tracheal suctioning so that their loved one can go home rather than to an extended nursing facility?

CASE MANAGERS CONSTANTLY REASSESS, MONITOR, EVALUATE, AND REVISE THE PLAN UNTIL THE DESIRED OUTCOMES ARE ACHIEVED.

Answers to these questions influence the type of care a patient will receive and how it will be accomplished to ensure the best possible outcome for a patient in the most cost-effective manner. Case managers who apply critical thinking and clinical reasoning skills in the decision-making process ensure appropriate, effective, and efficient care delivery. This ensures that the patient and family will receive the necessary support, avoid obstacles, prevent a readmission, and increase the chance of a positive outcome.

Negotiation

Negotiation is a skill that is not primarily taught in nursing or social work educational programs. To be a successful negotiator, a case manager must be a good time manager. Along with managing their own time, case managers must learn to determine what work others can perform in assessing a patient's needs when preparing a care plan. This understanding allows them to negotiate more effectively.

Negotiation in case management is an everyday occurrence. It is a skill used with payers and providers, with vendors for durable medical equipment, with the patient and family/caregiver, and even with physicians reluctant to opt for a home care discharge plan or placement in a long-term care facility. Fair negotiation requires trust, rapport, and complete honesty about a patient's care needs.

Successful negotiation is achieved through preparation and presenting the facts clearly and succinctly. To know if you have negotiated your case well, you must be a good listener and observer; otherwise, windows of opportunity can be missed.

On the financial side, we know all too well that healthcare environments are committed to doing more with less and at a lower cost. A case manager's financial prowess is a must in these times of cost containment. Case managers must work with financial support personnel and keep them abreast of a patient's insurance health benefit.

Summary

This month, we began our discussion about the skills needed to be an effective RN case manager or social worker in today's complex healthcare systems. The skills needed far exceed those acquired through one's professional licensure, and require expanded knowledge and skill sets to become a proficient case management professional. Next time, we will continue reviewing the leadership skills and communication skills needed to become a successful case manager. ■